Conference of State Mental Retardation Construction Authorities With the Surgeon General

OCTOBER 14–15, 1965
CHICAGO, ILLINOIS

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Public Health Service

PROCEEDINGS

1965 Conference Hill-Burton and Mental Retardation Construction Authorities With the Surgeon General

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
DIVISION OF HOSPITAL AND MEDICAL FACILITIES
Washington, D.C. 20201

foreword

This report of Proceedings of the Annual Conference of the Surgeon General with State and Territorial Hill-Burton and Mental Retardation Construction Authorities reflects the vigorous effort being made by the States and Federal government to find improved ways of meeting the Nation's health facility needs.

Speeches presented during the first day of the Conference called attention to the newly emerging concepts directed at making health services available wherever gaps now exist. Of particular interest, also, were discussions centered on the implications of newly enacted health legislation on the types of health facilities and services which will be needed throughout the Nation. As in previous years, the lively discussion periods provided a most useful forum for an exchange of experiences by representatives of the various States and Territories.

For the second consecutive year, the second day of the Conference was a combined session with State and Federal authorities responsible for developing programs for the construction of facilities for the mentally retarded.

Conference recommendations appear on page 48.

Harald M. Graning

HARALD M. GRANING, M.D.,
Assistant Surgeon General,
Chief, Division of Hospital
and Medical Facilities.

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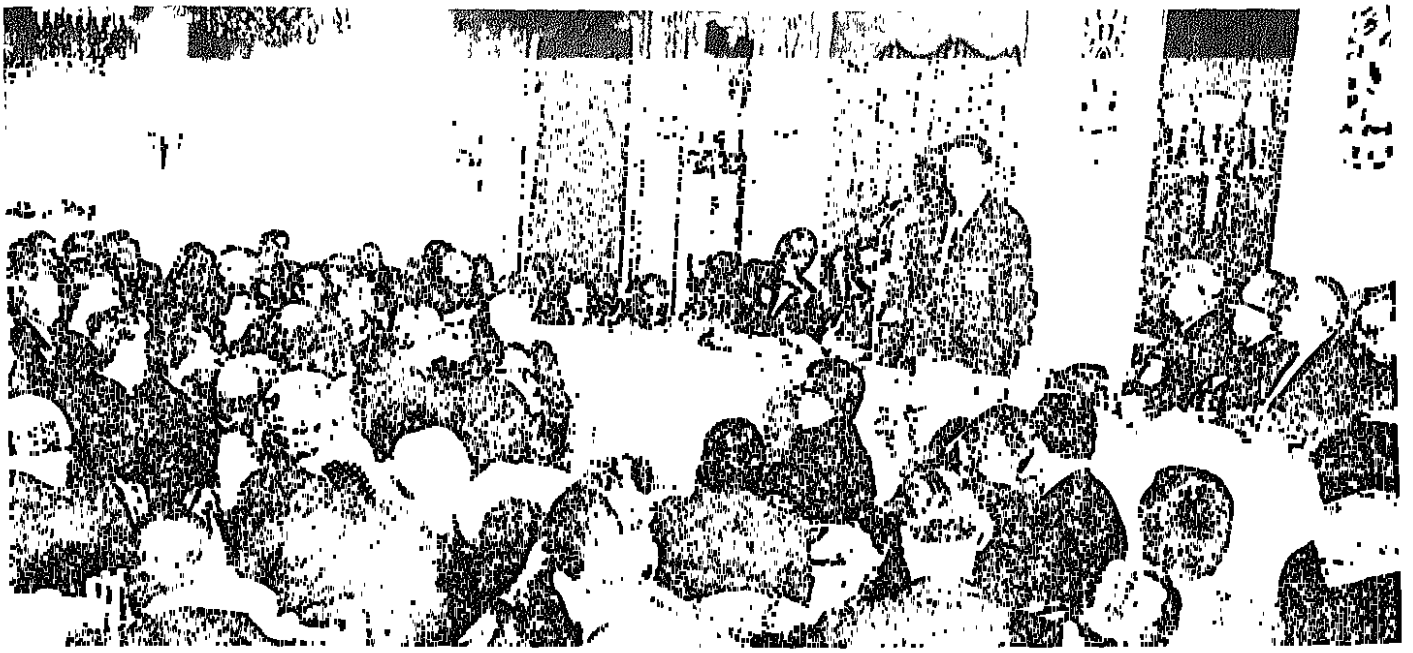
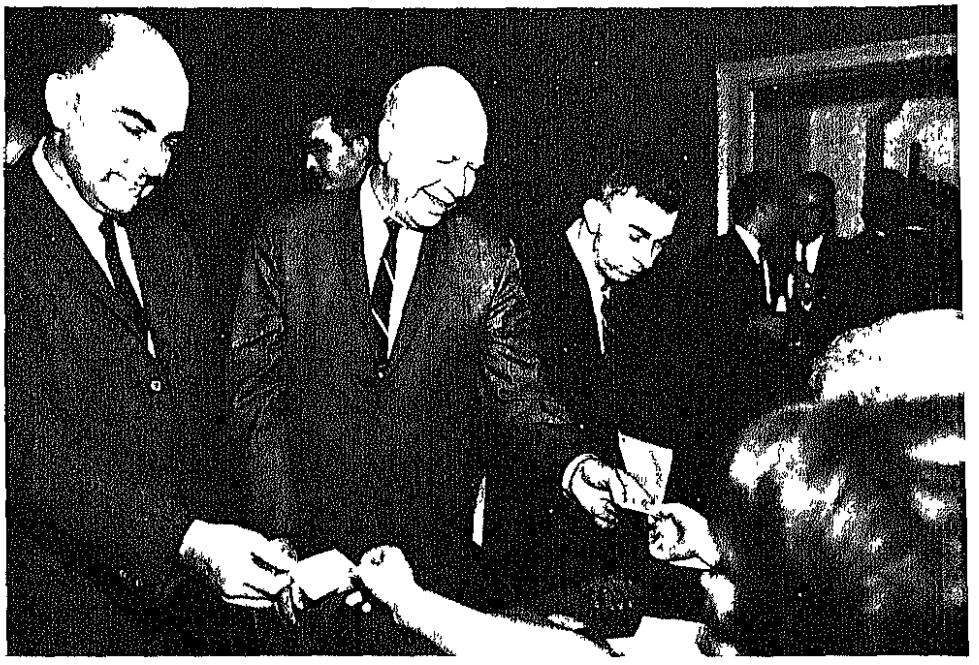


Dr. George James, former Commissioner of the New York City Health Department, delivers luncheon address.



Registering for the 2-day conference are Mr. John Chleapas, engineer, Boston Regional Office; Dr. Harold M. Erickson, Deputy Director of the California Department of Public Health, and Mr. Clarence R. Horton, Chief of the Hospital Services Section, State Department of Public Health, Denver, Colo.

Discussion group leaders receive gu
lines from Miss Ruth Richards, He
Education Officer, Division of Hos
and Medical Facilities. Shown
Miss Richards are Dr. Bernard Buc
Olympia, Wash.; Dr. Franklin D. Yo
Springfield, Ill.; Dr. J. T. Herron, L
Rock, Ark.; and Dr. Edwin O. Wi
Santa Fe, N. Mex.

program agenda

Opening Day

Thursday, October 14, 1965

SPEAKERS

OPENING SESSION

Harald M. Graning, M.D.
Margaret DuBois, M.D.

LUNCHEON SPEAKER

George James, M.D.

AFTERNOON SESSION

Mr. C. Wayne Tucker

Discussion Groups

Presiding officer was Dr. Terrell O. Carver of Boise, Idaho, President of the Association of State and Territorial Hospital and Medical Facilities Survey and Construction Authorities.

For It or With It

Harold M. Graning, M.D.

EACH OF US—whether located in a State, Territory, regional office, or in Washington—has found that during the past year, activities reached new heights, covered new ground, and made us feel we were in a state of perpetual motion. It is therefore most important that we come together for what we sincerely hope will be a refreshing experience. Hopefully, we shall have an opportunity to take a reflective look at where we have been, where we are, and where we are heading.

Are you FOR IT or WITH IT? In the vernacular of our younger generation, the two terms are far from synonymous.

When I was preparing my remarks for this occasion, approximately one-half million people in my hometown were looking forward to witnessing their first world series game. Folks who had not been able to distinguish a stolen base from a forward pass were vying with one another for tickets to a major sports event. There was no question about it. They were FOR baseball. They were FOR the Twins.

Meanwhile, in a certain Western city—whose name I cannot even recall—thousands of people were undergoing somewhat the same emotional experience. They too were FOR baseball.

However, in each instance there was a relatively small squad made up of a manager, a coach, and players, who were WITH baseball. They, the members of the teams and their mentors, were the only ones who had an opportunity to affect the score.

Scoring—or becoming sufficiently involved to change the situation—is being WITH IT.

In light of the leadership roles you fill in your own sphere of operation, each of you, I am sure, has frequently pondered the question of "FOR versus WITH." And it is highly likely that you reached the same conclusions when you identified the characteristics of those WITH a program.

To be "WITH IT" does not mean you are doing only what is required to get by. It does not mean that you'll permit yourself to become bogged down by routine functions, leaving no time to meet the pressing new problems of today or those which are fast approaching.

To be "WITH IT" connotes vigorous action as opposed to merely an assenting nod. It implies the ability to extend one's self above and beyond the bare essentials required of an assignment.

Since the early days of Hill-Burton, this type of forum has been used to let it be known what you were FOR as well as WITH. And, I might add, you were WITH IT when you let your ideas be known . . . when you called attention to the need for a more up-to-date Hill-Burton program which would give more attention to modernization, to improved planning techniques, to nursing home shortages, and to Federal aid to the States for assisting in operating costs of the Hill-Burton programs.

You were WITH IT when you called attention to the need for a Federal assistance program which would help resolve our health manpower shortages.

You were WITH IT as an organization when you helped call attention to the need for a vigorous program aimed at providing more adequate facilities for the mentally retarded and mentally ill.

Dr. Graning, an Assistant Surgeon General, is Chief, Division of Hospital and Medical Facilities, Public Health Service, U.S. Department of Health, Education, and Welfare, Washington, D.C.

You were for these and many other things which would give the Nation a real "heads up" health facility program. And you were indeed WITH IT when you extended yourself to communicate your ideas and help bring into being many of the gains we now have. Now that the machinery and wherewithal to put the wheels into motion are a reality, are you taking full advantage of your victories? Are you WITH IT?

In reviewing the activities of the past year, we find that the degree to which State agencies are WITH IT varies greatly. We are all aware that each State has its own unique set of circumstances which may either hamper or accelerate progress. But wherever roadblocks might be found, the challenge to "get with it" becomes the greatest. These agencies are finding they must extend themselves to new limits in order to affect their State's score.

And speaking of scores, what is our national "standing" in relation to the new functions assigned us over the past 2 years? States certainly deserve a large measure of credit for the record number of "firsts" or "hits" chalked up for fiscal 1965.

Briefly, those "firsts" may be enumerated as follows:

- First steps were taken in laying the necessary groundwork preparatory to establishing a grant program in fiscal 1966 to aid in modernizing obsolete health facilities.
- First matching grants were awarded to States under a new program designed to bring about coordinated planning of health facilities on a communitywide basis.
- First grants were awarded for the construction of schools of medicine, dentistry, nursing, and the other health professions under provisions of the Health Professions Educational Assistance Act of 1963.
- First grants were awarded to university-affiliated clinical facilities which train professional and technical manpower in caring for the mentally retarded.
- First State plans were approved setting forth needs for community-based facilities for the mentally retarded and comprehensive community centers for the mentally ill.

It was also a memorable and productive year in terms of implementing the nondiscrimination provisions of the Civil Rights Act and regulations as they apply to health facilities receiving Federal assistance. Headquarters and regional staffs provided advice and consultation on compliance to State agencies and individual hospitals. In addition, Division representatives served on Department teams which investigated complaints concerning alleged violations. We are well aware and are very grateful to many of you for your assistance and perseverance in interpreting and, if necessary, reinterpreting policies, procedures, and regulations in an effort to achieve the goal that there be no discrimination on the basis of race, color, or national origin. We are pleased at what has been accomplished and are aware of the continuing need for your help.

These are some of the "hits" we scored during the past year. However, as in baseball, there are sure to be some "misses"—some "errors." How did we measure up?

For some this may be a somewhat painful subject, but essential to any self-examination. It is my understanding that Hill-Burton program personnel have traditionally faced their problems. This is perhaps one of the chief reasons Hill-Burton has continued as a dynamic program for almost two decades.

A year ago when I addressed this conference, I spoke of the many opportunities which await us in both our old and new programs. In some instances your authority and responsibility are direct. In other cases, you have not been delegated an *official* assignment, however, as leaders of health matters in your State, your responsibility becomes inherent. Here I have reference to your role in stimulating interest in project grant programs from which your community would benefit. Examples are the Hill-Burton research and demonstration program, the Health Professions Educational Assistance program, and the program to aid university-affiliated facilities for the mentally retarded.

Let us examine some of this year's major activities a little more closely to get a more detailed scoresheet. We then will have a far better idea as to how many of us were truly "WITH IT"—were sufficiently involved to affect the score.

Federal Aid to State Agencies

First, let us look at a matter which touches closest to home—that of building your own State agency staffs. What happened nationally in regard to State agency authority to utilize 2 percent construction funds, or $50,000, whichever was the

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lesser, for meeting administrative costs of the program?

As you know, the 1964 Hill-Harris amendments made it possible for States to apply for Federal funds which would help carry out program leadership responsibilities. However, in order to qualify, it was necessary that each State provide operating funds which would at least equal those of the previous year.

The box score for fiscal 1965 looks something like this:

40 States requested funds.

14 States and territories did not.

Federal funds requested amounted to approximately $915,000.

This, when added to State-level expenditures of about $2 million, represented a 50-percent increase in the total budget for the 40 States involved. Actual expenditures were $2.4 million or a net increase of 20 percent.

Although cold statistics do not always tell the complete story, they do bring many questions to mind.

What happened in the States and territories which did not seek additional operating funds? Were they able to efficiently carry out all of their old functions and at the same time implement all the new programs?

And what happened in those States where proposed budgets far exceeded their expenditures? Was it because of manpower recruitment problems which all of us have and are experiencing? Or were other obstacles involved—obstacles which possibly might have been overcome if more members of the "team" were truly WITH IT.

Areawide Planning Grants

Next, let's move to item number 2—areawide planning. How many State agencies are giving sufficient attention to advancing this concept? How many States received grants during the past year?

The scoresheet reads as follows:

17 State agencies became eligible to receive grants totaling nearly $1.9 million. This will assist 33 planning agencies. Formerly under the Hill-Burton research demonstration program, 38 grants totaling $3.2 million were made to areawide planning agencies in various States.

3 additional States have projects pending.

14 additional States and the District of Columbia are developing projects.

16 States have yet to be heard from.

This audience certainly doesn't need to be sold on the values of areawide planning. Many of you here were among the first to advance this concept. There is need for communicating its merits to additional communities.

It was indeed surprising for me to learn recently that there are about 50 metropolitan areas with a population of 250,000 or more without an organized health facility planning agency. Four of these areas have a population of 1 million or more; 11 have 500,000 to 1 million; and 34 have from 250,000 to 500,000.

We would suggest that States in which these areas are located take positive steps to promote formation of new health facility planning councils, giving top priority to the larger areas. Specifically, it might be a good idea to enlist the aid of your State hospital associations and medical societies in this effort. As you know, both the American Hospital Association and the American Medical Association have strongly supported areawide planning.

There are substantial grant funds to help.

How does your State score?

State Advisory Councils

Next, let us turn to item number 3—State advisory councils. How many States have reconstituted the membership of their councils as required by our 1964 amendments?

At the time the law was enacted requiring that at least 50 percent of the membership of the council be comprised of consumers, only one State was already in compliance and five only required a shifting of memberships to conform. What has happened in the other States?

The box score adds up as follows:

5 councils changed by Executive order of the Governor.

11 States enacted new legislation changing their councils' composition.

31 States submitted letters of intent indicating that State legislation is expected to be enacted this year.

1 territory has yet to advise.

It appears that State agencies have done all that is possible so far in regard to this matter. It is during the current year that most of the States—31 of them—will have to follow through in regard to achieving the needed legislative change.

Mental Retardation Program

Item number 4 relates to mental retardation. What has happened to date with regard to the two programs which provide grants for the construction of facilities for the mentally retarded? Under one program, the Division awards project grants directly to university-affiliated facilities for the mentally retarded. Sponsors of such facilities have as a primary goal the training of persons who will work with the mentally retarded. In the other program, formula grants are awarded to the States which in turn provide grants-in-aid for the construction of community-based facilities.

First, let us review the progress made in the university-affiliated program in which your involvement is indirect rather than direct.

5 grants totaling $8,086,560 have been made.

2 were in Massachusetts, and 1 each in California, Maryland, and the District of Columbia.

1 grant for a project in another State has been approved but not funded.

Schools in 17 additional States and 1 territory have been in contact with our office concerning the establishment of such facilities.

In other words, about half the States have not been heard from. I am aware that many States will have no need for such a facility. I do recommend, however, that you examine your own State's particular need in this regard. Wherever warranted, prospective sponsors should be advised of the need for trained personnel and the opportunities to receive Federal assistance.

As for the formula grant program for constructing community-based facilities, we are hopeful that this year's activities will make up for what has been a late start. At last count, 31 States had submitted plans for approval or preliminary review. Of this number, 7 have been approved; 15 are in various stages of approval; and 9 are undergoing preliminary review. The allotments to the 31 States cover approximately two-thirds of the Federal funds appropriated for fiscal 1965.

Is your State in the scoring column?

Health Professions Educational Assistance Program

Item number 5 is the Health Professions Educational Assistance Program. Legislation recently passed by the Congress and currently awaiting the President's signature would extend the 1963 law for 3 years and broaden its provisions.

What has happened to date under this program?

In brief, we find

$127 million in Federal grants have been awarded to date.

These grants went to 58 schools and 2 teaching hospitals located in 31 States and the District of Columbia.

Applications are pending from 20 schools and 1 teaching hospital in 17 States and 1 territory. Three of these States and the one territory have not had previously approved projects. In addition, among the many letters of intent that we have received, schools in four additional States have been heard from.

Thus, 38 States, the District of Columbia, and 1 territory have either been awarded grants, have applications pending, or have expressed interest in building.

And so we find that about three-quarters of our States have made a showing so far. As for the remaining quarter of the Nation, let us hope that the State agencies have begun to generate interest and that the fruits of their labors will be known in the next year or so. However, if this is an area which has been neglected, let's GET WITH IT. Help your community score. In view of the great health manpower shortages being experienced throughout the Nation, this is certainly one program in which we should be batting 1,000.

Preventive Health Services

Item number 6 is an area in which I have had a particular interest since the beginning of my career in public health. I have reference to the

need for a more vigorous effort to make available to all of our people more comprehensive preventive health services. Such services would be provided not only in public health centers but in hospitals as well.

When I addressed this group in Kansas City in 1963, I urged that we encourage hospitals to give as much attention to preventive health opportunities as to curative and rehabilitative services. After 2 years of experience in this program, I would like to reemphasize my initial plea.

In this connection, I would like to share with you one of the most interesting observations that was made during my recent tour of Russia. Last summer I spent 3 weeks as part of a five-member delegation of American physicians visiting hospitals and other health facilities in the Soviet Union. When we visited these hospitals we found that few patients appeared to be very sick. We observed this repeatedly in every hospital we visited, and we began to wonder where the really sick patients were kept. This question was finally asked, and we were told that few patients suffer from serious illnesses since disease prevention is given major emphasis in the many polyclinics distributed throughout each city. Under what they call "dispensarization," patients are scheduled at specific stated intervals for followup examinations on any condition noted. They are excused from work for this purpose and apparently honor the appointments without fail. The Russians place great stress on their polyclinic program.

The efforts being made to encourage preventive medicine in this country vary greatly among our States. Some have done a most creditable job in mustering up sufficient community support to make it possible to build public health centers in their States. On the other hand, there are a few States which still do not have a single acceptable public health center!

How does your State score? I have on occasion speculated on what would have happened if no Hill-Burton support had been given unless a community had already or would concurrently provide for preventive medicine services by an adequate staff.

Consultation Services

My seventh and final item covers a wide assortment of thoughts which might best be brought together under one heading—the consultative role of Hill-Burton agencies.

When you consult with hospitals concerning their construction plans, what items do you call to their attention? Do you consider such vital matters as optimum utilization and how it might best be achieved? Do you discuss ways of cutting down on operating costs through participation in shared services? Do you encourage hospitals to carry on administrative research and demonstration projects for which they may be eligible to receive Hill-Burton grants?

The need for responsible research and controlled evaluation of new procedures, techniques, and equipment was recently given special attention in an address by Dr. Philip Bonnet, president of the American Hospital Association. Speaking at the annual meeting of the American Hospital Association in San Francisco, Dr. Bonnet cautioned against engaging in "fashionable and expensive rivalry for having the newest thing or trying out the latest idea if their values have not yet been established." Dr. Bonnet made the following observation, and I quote:

> "The amount of 'fetching and carrying' which still exists in hospitals is far too much. What is needed is not new gadgets or mechanization as such, but a new concept of hospital service with a clear, hierarchy of values and priorities which will permit and encourage the design of new, more effective, more comfortable, and more convenient hospitals."

As for consultation provided by our own headquarters staff, I am pleased to report that we have broadened our services considerably and expect to continue in this direction. In coming months we will initiate the provision of consultant services involving several disciplines.

To initiate this program we have assigned a nurse consultant to serve the New York and Boston regions and another nurse to serve the Chicago and Kansas City regional offices. We are fortunate in having been able to recruit two competent and personable nurses who are skilled in hospital operations. They have been given orientation to program objectives and we believe that those of you who are served by the Boston, New York, Chicago, and Kansas City offices will find them helpful.

It is not news to say that we have not been able to get first-hand reports about operational problems and successes that have stemmed from the design of hospital facilities. As in the case of moving into a new house, it is not until one lives in

it that he becomes aware of what changes in design would have made the home more liveable. We propose that one of the initial contributions of these consultants will be to visit facilities that have been built within the past 3 to 6 years and invite comments on what, if any, features have been particularly helpful and what could possibly have been improved. Such information will be shared with the State agencies concerned, with the regional office staffs, and with our headquarters staff in Silver Spring. We anticipate that during the course of such visits there may be opportunities to share information about other consultative assistance that is available upon request and to indicate the availability of guide materials if this is indicated.

You will be pleased, as are we, to know that we now have two staff members who are thoroughly conversant with environmental health problems. Other personnel are considering the best ways to be helpful in, among other things, such matters as systems design and use of computers.

Are you making the most of your leadership post by maintaining a free flow of communication with health facility planners, hospitals, and the public at large?

Members of our professional staff working independently, with others, or with ad hoc groups prepare publications which cover a variety of subjects ranging from hospital administration to design and equipment. These publications have been widely used throughout this Nation and in many foreign countries. And on occasion we are advised that translations have been made into foreign tongues. As State Hill-Burton authorities and program directors, you hold a key spot in your community to make these materials available wherever they might be needed.

Before leaving the subject of consultation, there is one area in which little work has been done which should be given special consideration. I have reference to the maximum utilization of hospitals as a learning experience for patients. Although being hospitalized is but an incident in the life of an individual, it can and should be made an experience which will bring him many health benefits in years to come. Every opportunity should be provided the patient to be aware of both his health limitations and potential since the hospital provides an excellent environment for education in recommended health practices. Unfortunately, few hospitals will be able to engage the services of professional health educators. As a result, patient education which is most essential is seldom put into practice. This is especially true of the average community hospital. Institutions affiliated with medical schools have a better record. Slightly less than half of these have active programs in patient education on an outpatient basis; however, such programs are usually not functioning with respect to inpatients. The patient education that does exist stems primarily from the interest of the physician and the nurse, with occasional assistance from the medical social worker. We do not deride or minimize their efforts. Rather, we wish to see them supplemented. Thus, I would suggest that thought be given to the establishment of education activities as an integral part of the program of many hospital voluntary service groups. The practical value of the volunteer in the hospital is well recognized. The volunteer program, properly organized, certainly lends itself to expansion to include the provision of education on a scale commensurate with the experience, education, and on-the-job training of carefully selected volunteers.

In this connection, I would suggest that hospitals would do well to think about creating educational auxiliaries. In establishing such auxiliaries, it would be wise to seek the aid of school teachers—particularly those in the science field who in most communities would welcome the opportunity to be of service. Ten to 15 teachers per 100 beds would be a good nucleus.

After the educational auxiliaries become familiar with hospitals, there are two ways in which they might best serve:

First, by assisting in patient education. For example, a diabetic would be taught how to manage his diet and a heart patient would be instructed as to his proper diet, exercise, rest requirements, and other matters.

Second, by alerting young people as to opportunities which await them in paramedical fields. Examples of positions for which there is an ever-growing demand include laboratory technicians, nurses, social workers, and dietitians.

The wide variety of subjects I have touched on under the general heading of "consultation services" merely suggests some of the many areas yet to be explored and developed. Are you turning your thoughts to some of these newer areas and making them known? Are you able to affect the score?

In conclusion, I would like to make this final

observation on what might be considered a panoramic view of our collective "hits" and "misses." Although the use of a dissecting microscope is essential when appraising one's batting average, it takes a telescopic view to give the appreciation of program significance which is so essential if we are to have the energy and the drive, to carry through in spite of obstacles. We could not possibly be functioning in a more exciting period as far as health programs are concerned. Everyone seems to show some willingness to help us succeed. To be sure, at times the view may be distorted or somewhat dim, but an awareness of the general nature of what is on the horizon is essential if we are to score in providing the best medical care possible for the people of our Nation.

And, finally, this little verso which perhaps, in essence, captures the spirit of my remarks:

A lamp spreads no light
till you've lit it,
A ball makes no score
till you've hit it,
So if you've a problem and
really must lick it,
Success will be yours
if you'll only GET' WIT'H IT!

How To Determine State Bed Needs

Margaret B. DuBois, M.D.

CONSIDERABLE TIME has passed since our first discussion of proposed new State planning methods and procedures for the Hill-Burton program. Frequent and long committee sessions were held, and a vast amount of staff work has gone into testing proposals using actual figures from a considerable number of State plans. Now all of this has gelled into regulations and State plan forms, and the first few State plans prepared under the new procedures have been submitted.

There are a number of changes. Some of these are designed to meet the requirements of the 1964 Hill-Harris amendments to the Hill-Burton legislation; some are the result of recommendations made by the Ad Hoc Committee to Review Hill-Burton Regulations, Policies, and Procedures.

Major changes for most States encompass (1) the use of standardized, uniform forms; (2) methods of counting beds; (3) methods of evaluating physical plants; and (4) methods of determining bed needs.

Although I am supposed to talk only about determination of bed need today, I hope you will forgive me if I say a few words about the other three changes first.

UNIFORM STATE PLAN FORMS

Uniformity of State plan forms was a feature of the Hill-Burton program in its early days. By degrees, it became evident that these forms did not supply all the information needed for good planning, so State agencies were permitted—even encouraged—to devise new forms. About 50 percent of the States did this; others used the standard forms and provided additional information. This inventiveness was good; most of the features in the new forms are the result of State agency ideas.

Although the new forms are required, the door is still left open; State agencies may provide information in, or on, any form they wish to devise, *in addition to the uniform forms provided.*

COUNTING BEDS

The necessity for uniformity in the counting of existing beds was emphasized by the inauguration of the modernization program. Prior to this, bed need had never been a factor in the formula for determining allocation of funds to the several States. In the modernization program, it *is* a factor. In the past, the Public Health Service staff had been adding not apples and oranges, which *do* have *some* similarities, but grapes and watermelons. This had less importance then in reports to Congressional committees and the Bureau of the Budget than it will have now, when funds are allocated, in part, on the basis of need in terms of the count of nonconforming beds.

For this reason, uniformity in the method of counting beds is very important. The Public Health Service will welcome any suggestions for improving the established method as long as the principle of uniformity is observed. This is in compliance with the Act, section 603(d), which specifies that the Surgeon General shall by general

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regulations prescribe "criteria for determining the extent to which existing facilities, for which aid under this part is available, are in need of modernization."

PLANT EVALUATION

The next innovation—the new plant evaluation procedures—is also a direct effort to comply with the same section of the Act. The only previous Public Health Service criterion for unsuitability—or nonconformity, as we now call it—was public hazard. Many State agencies, over the years, had developed criteria of their own, with wide variations. Although this is strictly an evaluation of the physical plant, several States had introduced factors related only to operation. Using such criteria, we *might* find ourselves replacing a building with public funds because it was inadequately staffed! I might add that I don't believe this ever actually happened or could have happened!

There is flexibility here, however. The uniform Federal standards must be applied—primarily to find means of uniformly measuring modernization needs—but State agencies may adopt more comprehensive or more stringent standards which may be used only in determining need within the State. The State plan forms make provision for separate reporting of beds which are nonconforming by State standards. Such standards must apply only to the physical plant and must be approved by the Public Health Service before being used in the State plan.

DETERMINING BED NEED

Now we come to the reason that I am here, according to the title of my talk—determination of bed need. The new procedures were set up to comply with Section 603(c) of the Act which states that "the Surgeon General . . . shall by general regulations prescribe . . . criteria for determining bed needs for general hospitals and long-term care beds . . ."

Most of us here today remember the early days of Hill-Burton when we had a ceiling of 4.5 general hospital beds per thousand population for the State as a whole, and used a varied bed/population ratio for different types of hospital service areas. As the years went by and State agency staffs began to recognize the tremendous responsibility they had taken on in planning health facilities for their States, it became apparent that the bed/population ratio did not always provide the right answer. The Public Health Service agreed and made it possible for the State agencies to experiment with methods of determining bed needs. About 50 percent of the States abandoned the bed/population ratios and developed a wide variety of more sophisticated planning methods.

Here again, State agencies have given leadership by applying actual experience in their procedures for determining general hospital bed need.

So the Committee, in its deliberations, adopted utilization experience as the first essential factor to be incorporated in any method used.

Consideration was given next to timing. Any major general hospital project consumes from three to five years during the period from initial discussion to the opening for admission of patients. Yet, in the past, we were programing on data already a year old! A few State agencies had already ventured into projections. It was learned that population projections could be obtained and supplied to the States, so a 5-year projected population became the second factor adopted by the Committee.

Occupancy rates have been the subject of much discussion lately, with talk of the cost of empty beds. It is understood, of course, that hospitals, unlike industry, cannot schedule daily production at 100 percent of capacity. If they scheduled elective admissions on that basis, there would be no room for emergency admissions. Further, it is not even possible to predict the length of stay of an elective admission. No one can look at a diagnosis and determine how many days the case will remain in the hospital, because patients are not cases—they are people. Different people react differently to an identical situation.

So a desirable occupancy rate was decided upon as the third factor. Since the national average at that time was about 76 percent, an overall occupancy rate of 80 percent was adopted. Recognizing that rural areas with very small hospitals could not reasonably be expected to maintain 80 percent occupancy, a factor was introduced which allows for lower occupancy rates in such areas.

The decision to determine need by area instead of by individual hospital was reached after considerable discussion. The basis for the decision was the need to discourage small hospitals in

multihospital urban communities. This is proving to be a real hardship in some metropolitan areas where several small, substandard hospitals are operating at low occupancy while the larger, better operated hospitals are overcrowded. It is time, however, that some steps be taken to cope with this problem. I am sure the authors and subsequent sponsors of this program are as much interested in seeing *good* care provided as in building new facilities.

There is no doubt that, in some instances, these small facilities will be good, well-administered hospitals. Their low occupancy is due to their inability to offer the range of services provided in larger hospitals. Tightening of licensure laws and procedures would not help in this situation. This should provide good justification for an upward adjustment of bed need in such a metropolitan area, if it is supported by continuing efforts by the State agency to persuade these small hospitals to combine, to convert to another category of health service, or to close.

The Formula

The formula for determining general hospital bed need, as set forth in the regulations, incorporates utilization experience, 5-year population projection, and a sliding scale desirable occupancy factor. It is to be applied to areas, not individual hospitals.

This formula, however, is designed first merely as an example of how the various required factors may be combined to determine need, and second, to make life easier for the State agencies who find it works. Any State agency, however, may devise its own formula, provided it incorporates, *as a minimum*, these three factors, and is approved by the Public Health Service *before it is used* in the State plan.

Whether a State agency elects to use the formula in the regulations or its own formula, there is additional flexibility permitted. Bed need, as determined by whatever method is chosen, may be adjusted in individual areas in which an unusual situation exists, such as the one just described. This adjustment may be upward or downward, but it must be clearly justified in a narrative description of the area.

Several proposed formulas have been submitted to date. Of these, three have been approved and others are under consideration.

One of the approved formulas is based on calculating current bed need by the formula in the regulations, but applying a minimum use rate of 500 patient-days per thousand current population for areas with little or no experience. To this bed need is added the beds needed to provide 500 patient-days per 1,000 estimated 5-year population increase.

The second approved formula projects average daily census for 5 years, adjusts this by a factor for 5-year population change, and applies the square-root formula, modified to level off at 80 percent occupancy. In this formula, need is calculated by individual hospital. Permission for this was granted with the requirement that programing in the State plan must be done by individual hospitals.

The third formula, approved this week, is the Public Health Service formula using a 5-year projection of use rate.

Projection of use rate for 1 year is permitted in the Public Health Service Health Grants Manual, Part 23–2. There is some feeling that this is too restrictive, so projection up to 5 years will be considered if a statistically sound method of projection is submitted with the formula.

Determining Need for Each Hospital

Determination of bed need for each individual hospital, if desired, may be submitted for approval. This may be done by the Public Health Service formula. The procedure would involve calculating the use rate for each hospital, using the current *area* population, and projecting it by the 5-year projected *area* population. If need is determined by the individual hospital, the State plan must show programed beds for each hospital. This procedure—which is *not* recommended—has little advantage beyond showing the actual number of beds needed by each hospital. It must be justified to be approved, and the State agency should remember that it will lead to programing more additional beds in the small hospitals than in the larger ones.

Some States in the past have made a habit of setting up a very tight program, then amending the State plan when a good project comes along. Such amendments may increase the number of beds needed, or decrease the number of existing conforming beds in an area, or both, with a resulting

dramatic change in priority. In situations like this, the State plan has no meaning. The plan *must* be accepted as a true reflection of the existing situation and a reasonable program to meet needs. Such amendments will be approved only when there is a radical change in conditions within the area, which change can be and is adequately described in narrative form.

Long-Term Care Facilities

In determining bed need for long-term care facilities, even greater flexibility is permitted. If you have studied the August amendments to the regulations, you will know that State agencies are *urged* to make adjustments in the need as calculated by the formula. In many States, it is recognized that statistics from long-term care facilities are not too reliable. Further, the unmet need represented by persons who need, but have not been able to use, such facilities is practically unknown.

Adjustments may be made for individual areas, or overall for the whole category, or both. Adjustments for an area must be justified in the area narrative; generalized adjustment must be described in the chapter on general operating policies.

In conclusion, I should like to say that we will welcome any constructive suggestions for improvement in the format and methods of preparing the State plan. Any such suggestions, if consistent with the requirements of the act, will most certainly be given very careful consideration. We hope you understand our objectives—because we need your help to achieve them.

Health Facilities in the Total Medical Care Complex

George James, M.D.

MY REMARKS TODAY will relate to the general problem of where health facilities fit into the total medical care complex, some of the major problems we will face in the coming years, and some of the attempts being made to determine the future pattern we would like to develop. Several very significant factors should be recognized at the outset.

First of all, our medical care system, as we see it today, grew up in response to a need for health services. That need has been changing and now it is changing with extreme rapidity and thoroughness. It is no longer an acute disease problem. It is no longer a curative medical problem. It is largely rehabilitation, limitation of disability for the aged, finding causes of disease, and getting people to live in a certain way so that they do not develop chronic diseases in later life.

For this, our present medical care system is not well oriented and there are obviously, therefore, needs for major adaptations for the system. We cannot erase this system. If we had it to do over, I dare say we would end up with something quite different from what we now have. It is, of course, impossible to do this, so we look to the system to develop that flexibility of approach and that attention to those needs which will lead to a program in the future.

Now I have given you the substance of my whole talk. Anything else I say will merely try to explain it.

FOUR STAGES OF DISEASE

I must begin by talking about epidemiology. We have found it convenient in discussions like this to divide the natural history of disease into four stages. By "natural history of disease," I mean what happens with a given disease in a given patient, including the entire progress of the disease, all the many ways it develops in that patient, the period before it develops until long after it has ceased, and its effect upon the patient. By "effect," I mean to include all of the short- and long-range effects.

First Stage

The first of these stages of disease is that period before the disease begins, the prepathogenic phase. In this period the important factors are those which make an individual more or less susceptible to a disease—the kinds of cigarettes he smokes and the amount, the kinds of ice cream he eats and the amount, his hereditary pattern, his occupation, many of his other health habits, whether he is immunized or not, whether he has routine medical examinations or not—all of the things that put a patient in a higher or lower category with reference to the risk of getting a specific disease. It is interesting that in our present health programs and present health status in the country, we are doing a relatively miserable job of considering these factors.

Because we are interested in that need and the goals we have for public health in this country, we cannot just sit back and pat ourselves on the back for having conquered typhoid, diphtheria, and smallpox. These are not our problems today.

Dr. James was Commissioner of the New York City Health Department at the time of this meeting. On November 1, 1965, Dr. James assumed his new post as Dean, Mount Sinai School of Medicine, New York, N.Y.

But look at the 20 leading causes of death today. We are able to demonstrate our ability to effect a major impact against very few. If you consider what could be done about them, you will see that we are not doing those things related to the removal of risk factors. You will see that we have a big void in this field in our present medical care structure. It cannot be shown that we have come to grips with this problem.

The converse of the story is that the individual citizen is not very much interested during the prepathogenic phase. He feels no pain during this period. He can read many advertisements telling him to avoid this and that, but he has little motivation. He feels that no immediate medical payoff exists to motivate him to change his habits; therefore, it is close to a complete void. The individual hospital or department that wishes to enter this field has a wide open territory that has been relatively unexplored.

Second Stage

The second stage of disease relates to pathology subject to early detection. During this period the disease process has begun, but the patient is not aware of it. You can, however, find the existence of disease by doing various detection tests. Here, too, the priority given by our citizens is extremely low. People do not feel pain. They do not see the need to take time off from work, to travel long distances, to wait in clinics or the private physician's office to receive this medical care. Some of it is painful. Payoff, again, is far removed from the difficulty of seeking care during this stage of disease.

Surprisingly enough, this low priority is also the rule on the part of medical care institutions. The hospitals give stage two medicine short shrift in most cases, and I know no hospital that does as complete a job as could be done. In New York City, where we have given much attention to this, we are still finding less than one-fortieth of our unknown diabetics who are walking the streets. Less than one-fiftieth of the annual crop of unknown cases of carcinoma of the cervix are being detected. And we are still finding only one out of each two cases of infectious tuberculosis in spite of the fact that we have one of the most extensive and far-flung tuberculosis casefinding programs in the country.

There is a wide-open field here. Your hospitals are full of patients who have other diseases which are not being detected.

Third Stage

Stage three is the clinical phase. This is when the patient has accepted the fact that he is ill. He goes to the doctor and says, "I have pain, I want help." At this stage American medicine has been at its best, because people have always given this high priority. When they are sick, they have demanded care. We get into the trap, however, of equating need and demand. Need, as such, requires a more scientific degree of measurement than merely the fact that the patient demands it. But even in stage three, clinical medicine, difficulties exist. We fragment the human being and the human family into our many specialties. We send him to one place for mental health, we send him to another place for his liver, another for his heart and kidney.

The accent in the third stage of medicine is on biologic cure, however, in most of the chronic diseases which are major causes of death today, we have no biologic cure.

Fourth Stage

The fourth stage is that in which we have given up the hope of biologic cure and recognize that the disease is chronic. Here we hope for a different payoff. We have sick care, and we have social care which consists of disability limitation and rehabilitation. Whereas the individual may wish to give priority to this because of his aches and pains, he finds it difficult to elicit an adequate response from treatment institutions. These are the kinds of people we are remarkably skillful at keeping out of hospitals. These are the kinds of people who end up in our nursing homes, and since the hoped for result is nonmedical, merely social, it is difficult to get doctors interested in this because they can't use their familiar medical techniques.

These four stages of disease can be taken in one package. In my opinion, public health, preventive medicine, and medical care are all one. Any distinctions we make in these three terms in our lectures to students are purely transitional, reflecting the fact that we have not made sufficient medical care progress. If we had a truly adequate medical care program, they would all be the

same. In effect, medical care, public health, and preventive medicine equally involve anything anyone can do to interrupt the natural history of disease in favor of the patient. That could consist of building hospitals, or of immunization, surgery, or health education. The fact that a doctor is not always the best person to do each aspect of this has disturbed doctors greatly. The major objective must be to meet the Nation's health needs. I don't see why we should reform this goal just because a given profession finds it difficult sometimes to broaden its aspects and responsibilities. I feel that the medical profession will overcome this difficulty and that trends are being developed in this Nation to show us that it can be done. All of us who are in a position to do so should help.

THE "CUT-FINGER" EMERGENCY

Let me tell you a little story.

Let's imagine a woman who comes to the emergency room of the general hospital at 3 a.m. with a cut finger, bleeding profusely, with a handkerchief wrapped around it. She is seen in a relatively short time by an intern. He washes the finger with antiseptics, drapes the lesion, sutures it, and bandages it. He then tells her to return in about 7 days to have the stitches removed.

This is an example of high-quality medical care in 1965. I hope by 1975 this will be an example of exceedingly poor medical care. I hope it will be used as a classic example of poor care. If the intern had looked at this woman even casually while she was sitting in the waiting room, he could have seen her reading a magazine, holding it at arm's length with the hand that wasn't cut. So he missed an opportunity—not then but maybe later—to follow up and to find out that her glasses were no longer helping her because she was suffering from and was in the fourth stage of the disease presbyopia. He could have easily rehabilitated her, perhaps thereby preventing her from cutting her finger again.

Then, if he had put her up in stirrups, and done a Pap smear, he may have discovered the disease carcinoma of the cervix. And so, he missed a good opportunity to practice the second stage of medicine for that disease.

Then finally, if he had observed her further, he could have seen her lighting a cigarette with the butt of another. And so he missed the opportunity of practicing first-stage medicine for several diseases, namely, carcinoma of the lung, coronary heart disease, carcinoma of the larynx and emphysema.

Now, what did he do? He treated her finger—the third stage of the disease, cut finger. He completely ignored and did nothing about treating a patient who was suffering from other stages of a flock of other diseases.

QUALITY CARE

What this leads to, then, is a definition of what we mean by quality of medical care, because if we are talking about medical care in the future, what do we really mean? We have defined the quality of medical care over and over again in a very limited way by saying it means that physicians giving medical care to an individual patient must possess the appropriate skill. Hence, an individual who removes a lung should be a competent chest surgeon, a diplomate of the American Board or the equivalent. This is one of the aspects of quality medical care, but this is only one of several. I would say that others are equally important.

Number one would be continuity of care. Ideally, the patient should be treated by the same physician, or group of physicians, or at least a continuing medical record should follow that patient throughout his life.

Second, attention should be given to the total patient and not alone to the chief complaints. We have been practicing too much "chief complaint medicine" in America. The patient seeking medical care is a patient at various stages of various diseases, and it is up to us to be concerned with this, to set up some kind of a regimen for finding them and doing something about them. Incidentally, unless we can develop some such regimen for picking up first- and second-stage problems, we are going to miss a great opportunity to do a tremendous amount in the attack on the major chronic disease problems of our day.

Now, I will pause to say parenthetically that some physicians have argued with me that our knowledge of first- and second-stage medicine is not that good. They argue that we don't have absolute proof that high saturated fats in the diet raises one's cholesterol, causing death from coronary heart disease; that we don't have the data to prove beyond all doubt that if a person is too fat, he has a tendency to get diabetes and that if he loses weight, this reduces the tendency; that we don't have absolute proof that cigarette smoking causes disease; and so on.

In reply, let me merely say this: These individuals have been guilty, as have all of us, of double-standard thinking. When a patient comes to the physician in the third stages of the same diseases, we go through an enormous amount of effort and medical activity. The scientific knowledge upon which much of this medical activity is based is equally deficient in final proof.

We do not yet have positive proof that dicumarol will prevent coronary heart disease and stroke. The medical care given coronary patients (oxygen, supportive measures, etc.) has not proved tremendously effective. Case for case, point for point, lesson for lesson, those things we can do in the first and second stages of chronic disease can hold their own very well with respect to scientific proof as compared to the things we do in the clinical area. Of course, there is the difference that the patient does not demand them at this early stage, which suggests, perhaps, some ways of engineering such services a little differently.

In measuring the quality of medical care, we have the problem of medical care which should be patient-centered and family-centered. Family-centered care provides an opportunity to bring in a large number of people into medical care. Once they are brought in, you have an opportunity to tackle their first and second and fourth stage medical problems. These problems are not great enough to motivate the patient to come to you, but if you can get them in this family arrangement, you have the opportunity to do this.

The last aspect of quality of medical care which I will note here is one which practically no medical care institution in the country can meet. In the future a medical care institution will be measured by its ability to serve the unmet medical care needs of its community. Putting it medically, you can see that if in the community around a teaching hospital there is any large collection of people who need care for any of the stages of disease but are not getting it, then the medical care of that institution cannot be rated as being of high quality.

Hill-Burton is a community concept in itself. I think medical care legislation, public health services, all of the things that deal in medicine and health today shall push more and more toward this community concept of medicine. The ideal would be medical care institutions which would feel the responsibility for those patients who live in the area but don't come to them. They should feel this responsibility as strongly as they do the responsibility toward the patients who do come to them.

FALLACIES IN MEDICAL CARE SYSTEM

With that little background, let me list briefly the number of things which would be called evidences of maladaptation in our present health facility arrangements. In other words, granted these are the problems, granted this is somewhat close to or at least reflective of the above problems we are going to face in the future to improve public health, what then is the current story in our health facilities? What are the existing evidences that our health facilities are not adapted to meet these problems? I am sure any of you could offer a long list. I will note a few.

The Unadmitted Patient

First, we have the fallacy of the unadmitted patient. Some don't go to the hospital because they don't want to. Others don't come because hospitals are remarkably skillful at keeping them out—drug addicts and alcoholics cannot get into hospitals, the aged patient, the so-called crock. "Crock" is an interesting term. As you know, a "crock" is an uninteresting patient. What is an uninteresting patient? He is that patient whose sickness is so complex that we are unable to solve it. Therefore, we blame the patient, not our own failure to help.

The Ambulatory Patient

Then we have the ambulatory patient fallacy. Ninety percent of today's care is given to vertical patients. Yet in a great many institutions we have our finest doctors perform only on horizontal patients. The best doctors are relieved of the responsibility of participating in ambulatory care.

The Emergency Patient

The third fallacy deals with the emergency room. This is the fastest growing source of medical care in many areas of our country today. It meets a tremendous social need. Yet the emergency room, while it is capable of treating cut fingers and broken arms, is incapable of taking

care of individuals with chronic heart disease, chronic diabetes, nephritis, stroke, and so on. Yet, 30 to 40 percent or less of patients presenting themselves to emergency rooms are true medical emergencies. Most of them will require long-term continuous comprehensive fourth-stage medical care.

The Undiagnosed Patient

Another fallacy is the undiagnosed patient. In episode after episode, we have people going to a clinic which specializes in one organ who develop major pathology in some other organ. The individual clinic which has been responsible for this patient has been so interested in one disease, one organ, that it has not fulfilled its responsibility for the total patient. Our hospitals are filled with undiagnosed patients, undiagnosed in terms of other stages of other diseases.

Precursors of Disease

Then we have the lack of treatment of the precursors of disease. If a patient is found in your medical care system who is a heavy smoker, this is a far more serious disease than most of the conditions that might have brought that patient to the hospital in the first place. To what degree do we accept this responsibility? To what degree do we even follow up in this regard?

Hospital Competition

The sixth fallacy is one with which you are all very familiar—that is, the extra staffing of our institutions, the competition between hospitals. We have had one individual in New York City make the acute observation that there are three places in Lower Manhattan where the medically indigent patient can have open heart surgery, but there are no places where he can have his teeth fixed. We are approaching the time when there will be almost as many cardiac surgeons in New York City as there are patients needing cardiac surgery. There are, of course, definite values to this technique. Maybe it will be the answer to coronary heart disease some day, and I would not in any sense of the word cut back on the training of an adequate number of cardiac surgeons.

But there is an equal responsibility to look at total medical needs in the community. If this includes dental care, then this is something we should provide. If each institution duplicates and develops extra staffs, this interferes with its ability to devote its attention and sources to meeting other needs.

Fragmentation

We have fragmentation where integration is needed. We had one man, aged 76, who was told to go to 10 hospital clinics. This old man was far too sick to go to 10 hospital clinics, so he became an uncooperative patient. Well, if he hadn't been an uncooperative patient, he would have died, because it was quite beyond his physical capacity to go to a hospital miles away, sit in a waiting room for long periods of time, spend hours in line at the pharmacy for drugs, and go from clinic to clinic. What happens to these people? They end up in nursing homes.

The Nursing Home

A nursing home is in itself an enormous fallacy in our medical care system. Here we find patients with diseases so complex, so difficult of solution, that instead of making them the number one priority for our best research and medical brains, instead of bringing them into teaching hospitals in large numbers, getting our best scientists to study them and work with them, we do the exact opposite—refuse them admission, get rid of them as quickly as we can, and put them in a nursing home where they get some of the worst medical care of which we are capable.

Concentration on Acute Cases

Then we have concentration of medical care institutions on the acute and clinical, again the third stage of medicine. This is fine, except for the fact that the unmet need in our country today is in the area of chronic illnesses where problems are not acute and they are often not clinical.

Denial of Staff Privileges

Then we have the curious fallacy of that individual physician who is most interested in comprehensive family medical care. He is the general practitioner. We have so arranged our society of

medicine that he is the one person kept at the longest arm's length from our best medical care facilities. In my own city, for example, hardly any general practitioners are admitted to our best hospitals. I am not for one instant suggesting that we lower the standards. I am merely pointing out a fallacy of our present arrangements for medical care.

The one person who is interested in integration, who is involved in trying to tackle the first, second, and fourth stages of medicine, is the one kept farthest away from the best health facilities in the community.

Dr. Robert Haggerty, professor of pediatrics at the University of Rochester School of Medicine, last summer looked into the practice of general practitioners and found them doing an amazing amount of first-, second-, and fourth-stage medicine. I don't know the degree to which this is true in the Nation, but if it is, then perhaps the general practitioner may not be all that lacking in a future because he is meeting a problem which may not be met in any other way. And one of the major questions confronting us is how to bring this interest on the part of the general practitioner into the best medical facilities we have. I am not telling you that the existing general practitioner is the best one to do it. I am just saying he is serving some kind of purpose, which is not integrated with the rest of our medicine.

The Community Hospital

We definitely have a lack of responsibility for community problems. One of my stories in this regard is that when I was talking to the staff of a local hospital in New York and asked them, "How would you like to move more toward being a community hospital?" The director of internal medicine gave me a fishy stare. He said, "What do you mean by a community hospital?" I said, "Well, there is no time to give you a long, prepared talk. I will tell you in just two sentences: There are diabetics in New York City in the area around your hospital. Sentence one. Sentence two: We in the health department will find the diabetics through a detection program and when we find them we will turn them over to you for treatment."

Whereupon he became completely horrified and said, "Well, I have enough diabetics."

I said, "Well, this is what I mean by a community hospital. Let me go one step further. Suppose we say there is a 50,000 population in your hospital area, and with normal detection yields, we find a thousand diabetics that need a workup. Maybe we can do this workup on an outpatient basis with doctors who are related to your staff, but who would work in clinics in our own district health center. Then we would find among these thousand diabetics 50 real interesting diabetics with flame hemorrhages of the retina, with neurological disease, and some which do not respond to insulin."

"Oh," he said, his eyes getting big. "I am writing a paper on that. That is just what I want." Well, how does he expect to get these unless we can develop some major community programs in his area?

So, it is possible to develop a partnership and let the profession of internal medicine have what it wants, and then use a little bit of its prestige or influence to help the health department or cooperating agency develop its part, and together we have a community program.

We certainly have lack of feedback from the community. I have seen hospitals around the country developing highly specialized programs when communities around them were crying piteously for a totally different kind of program. One hospital, the Gouverneur Hospital in New York, did a small study on the needs of its community. They were impressed with the enormous problem of dental care. Together we moved in with extra services and developed a dental care program. This has become the most popular program in that institution. I am not saying that popularity is the final answer. I am saying that there was a need, and lack of feedback through the years had allowed these institutions to go off entirely on other programs without any concern for dental care. This institution was ready to build a new cardiac surgical wing and had never before been interested in the real needs in this area.

The Teaching Hospital

Another fallacy is provided by the teaching program of the teaching hospital. What is the teaching hospital teaching? In Boston, Dr. Kerr White demonstrated that out of 1,000 adults, 700 of them became ill within 1 month. Of those 700 ill, do you know how many became patients in the teaching hospital? The answer is one. So, in teaching our medical students today, we are primarily teaching them from that one case of 700 sick, out of a population of 1,000. This is hardly medical education in terms of what illnesses our

people have and the major health problems and needs of our day.

Then, we have the problem posed by the proprietary hospital. This is a problem in many areas, where some of our best doctors are weaned away from teaching hospitals to a proprietary institution with, at the moment, generally lower standards in education and training than are present in the good teaching hospitals.

Control of Hospital Admissions

The last item on my list, which could have been a lot longer, is the fallacy of the control of hospital admissions by resident physicians. There are few professors who will battle the resident on this point. I am not saying that the resident should not have the teaching material he needs. I am just saying that the present admission policy of our teaching hospitals is a fallacy in terms of the health problems of the community.

THE GOAL

What do we do about all this? The goal, of course, is universal access to high-quality, comprehensive health, and medical care. If I were talking 10 years from now, I would hope to say only universal access to medical care, because by then perhaps all of the other adjectives would be understood. But they aren't yet.

This goal is not controversial. Everybody wants everybody to have all the care he needs and wants that care comprehensive. How we reach that goal is what causes all of the bitter arguments.

One step is to improve access. This is done by removing barriers. The major barrier, removed partly by Federal Government, is that of finances. Medicare is largely a minimal program. It does provide services at minimal cost for a group of people who found it difficult to get this care before.

But there are many more barriers other than economic. So far, there have been no imaginative programs in this area. There are geographic barriers. There are educational barriers. We have found, for example, when a clinic is open from 9 a.m. to 4 p.m. that it is very difficult to reach working people. That is why they go to emergency rooms at 3 a.m. If you expect mama to come, you must realize that she can't until she gets somebody to watch her five children. If you could arrange a family clinic at 7 p.m. and invite the entire family, then perhaps they would be more apt to come. Some of the demonstration programs now underway indicate that this is true. When you arrange services in a way which fits in with the existing capacity of patients, this will do it.

In the past, we have provided services, then tried to educate people to use them. This is good, but then you must study the unmet need. If you find individuals are not using the services because of insufficient motivation with respect to this pattern of care, what do you do? Of course, you try more education. We have a girl known as a social worker. Once I defined a social worker in a meeting of about 2,000 of them—and I really got out alive—as a girl who tries to fit a square patient into a round program, because what the social worker does is try to guide the patient through the maze of existing facilities.

But why don't we try another approach? Why don't we rearrange some of the programs to fit the existing motivations of some patients?

Let's take as an illustration—the control of carcinoma of the cervix. We opened a clinic in New York and found that mostly Jewish women came. Very few had cancer of the cervix. We then decided to move the clinic to the Harlem area because we knew there were many there with cancer of the cervix. We still found that most of the people who came were Jewish women—they simply stayed on the subway a little longer to get to the clinic.

Let's face it, in Harlem there is a struggle for existence, and the need to come for a Papanicolaou smear is low on the priority of life. We eventually opened a routine detection service on hospital admissions. All the women in this area, when ill, were admitted to two hospitals. We saved over 300 lives through this little program alone in just a few years.

What did we do? We arranged this service to fit in with the existing motivations of the patient. Patients were willing to come to the hospital for various clinical problems. Taking advantage of this, we performed a great many detection examinations which alone could not have motivated the patient to come to the hospital.

In attempting to reach the long-range goal, we have to go through certain intermediate steps. What are these steps? Let's admit first that the goal I have presented is a good one. Let's admit

that the facilities, the hospitals you are building and running are good ones, and that they are operated by sensitive, flexible people who would like to reach that goal some day.

How do we go about effecting improvements? How do we get the hospital to adapt? The hospitals will not ordinarily adapt by themselves. They have to be pushed, or they have to be pulled. They can be pushed by some rules, by some regulations, and that has to be done gently, but firmly.

For example, in New York City, we have said to hospitals, "If you wish to be paid by the Government for care of medically indigent patients, you will have to do certain things which provide high-quality medical care. Otherwise, we are very sorry but we can't give you the $36 or $40 per day." Very few hospitals in New York would like to give up $36 or $40 per day. *What we need in this country, in my humble opinion, are more programs which offer bonuses to those institutions which show themselves willing to develop new progressive demonstration type programs which will feed back into the institution and reshape them to meet health problems, present and future, along the lines we have mentioned.*

We have used a particular technique in New York City. We have our own little NIH in New York. Eight million dollars per year are awarded for research. We have a group of scientists organized like the NIH study sections and councils who recommend how it should be allocated.

We gave a large amount of money to a study group at Cornell University which ran a medical care project for a welfare population. As soon as families were admitted to public assistance, they were called in and given a complete medical workup. They were seen in the outpatient department. They were followed on the wards. They were seen in nursing homes, and they were part of the regular home care continuation program. In other words, they were given comprehensive, professionally competent fourth-stage medicine. We couldn't force them to come in. Between one-half and two-thirds did come in. Why the others did not come in is another problem which must get attention later.

When Cornell University did this, certain strange things happened. For the first time in its existence, Cornell had to have signs printed in Spanish placed in the waiting room. This was a new population coming into that institution, presenting new types of problems. Physicians at Cornell were now able to study health problems as they existed in their area. Also, from the data on utilization, we find that these people have very low utilization rates for home care. They would much rather come to the clinic with their families to see that doctor who is following them on a continuation basis. A study is also being made of the cost elements involved.

A less costly program of this type was conducted at St. Vincent's Hospital in New York, which had a small grant. Their staff began to approach the feedback and adaptation mechanism in a little different way. They began with selected patients in their outpatient department and then called in the families of these people. On some they had records, on some they did not. But they put together the pieces from their hospital records and manufactured a family record. Then they invited other members of the family to come for a medical examination and they created a special family clinic to take care of them. This program has had an enormous effect on outpatient care in that institution. The staff has seen the value of this program.

Another institution is studying emergency room admissions to see to what degree these patients can be placed into a medical care system where more is done for them than merely pushing them through the revolving door and getting them out. This institution is also working with the Health Department on a number of joint clinics.

We had another institution which investigated the prevalence of neuromuscular disorders in an area of New York to determine how to rehabilitate these people. They are also studying whether rehabilitation services for stroke patients early in the course of the disease can prevent the disease from getting worse in terms of the rehabilitation potential.

One hospital opened a small branch clinic in a housing project where 1,500 old people lived. Two internists who staff this clinic are able to prevent the need for 90 percent of patient visits to the hospital clinic 4 miles away. This is a medically indigent group. This plan offers an enormously greater opportunity to reach aged patients. This is bringing service to the patient in a way which makes it used.

A voluntary hospital is teaming up in a comprehensive program with a city hospital and the departments of health, mental health, and welfare. The director of this hospital is responsible for all of the health, hospital care, welfare medical care, and mental health care for over 150,000 popula-

tion in Lower Manhattan, New York City. The attending staff of private physicians are caring for the patients in this area who can afford private care, and the clinics are treating the medically indigent. One of the first things the director found necessary was to establish a number of satellite clinics. Although outpatient tripled within a year and a half, he still is not reaching enough of the 150,000 people. He therefore will open branch clinics so he can be closer to the people who are in need.

One of the interesting byproducts of these projects in New York City is the development of positions in a large number of hospitals for experts in community care. This is of particular interest because this is the way they can recognize their responsibility to the unmet needs in the community.

Then, finally, I will just say one word about categorical versus general approaches. In the past we have looked at approaches through the eyes of an agency, a building, a facility, or from the point of view of a profession. What we have to do is to look at the approach from the standpoint of the patient. The individual who can teach an 11-year-old not to smoke is much more effective in the control of lung cancer than the chest surgeon. We are going to live with categorical specialists and categorical approaches for a long time. This is good and must be done, because we certainly want to know more and more about less and less. But on the other hand, at the point where the service reaches the patient, let us learn how to develop the ingenuity to integrate and coordinate our efforts around him.

Health Insurance for the Aged and Its Effect on Health Services

C. Wayne Tucker

I AM DELIGHTED to be with you to tell you something about the posture of the Social Security Administration and the Department of Health, Education, and Welfare in the administration of Medicare, something about the responsibility that will be carried by State agencies, and some of the problems that we may anticipate in implementing the program.

When the program goes into effect in July 1966, virtually all aged people will have available to them, health insurance protection which is comparable to the best kind of protection now available to employed groups.

Because the program will enable individuals covered by social security to finance quality health care, it offers a stimulating challenge to those involved in planning for the availability of high-quality health care.

Since this is a conference of building authorities in the Hill-Burton and Mental Retardation programs, it might be useful to explore briefly the potential impact of Medicare on utilization. Governmental commitments to the health care of the aged are already very large. Consequently, as one aspect of the potential impact of Medicare, one would expect to see a considerable shift in the source of such financing. Whether or not there will be any great impact on utilization is another kind of question.

The new program will underwrite most costs for services which now represent about 15 percent of all admissions in acute general hospitals and probably more than 25 percent of all the days of care in acute general hospitals. Many newspaper stories have expressed fear that, as a result of Medicare, there will be overcrowding, a great shortage of beds, and complaints about benefits which cannot be delivered because facilities are not available. While it is true that all of the services covered under the program are not, or will not be, equally available throughout the country, many of the concerns expressed are too pessimistic, especially with respect to the availability of hospital services.

To some extent, even in the areas where there are hospital bed shortages, the difficulty will be somewhat minimized by the timing of the health insurance plan. The beginning date is such that any backlog of need for hospital care among the aged will hit the hospitals at the best possible time. July and August, the first 2 months we will be paying for care, have about 10 percent lower utilization rates than the peak months of February and March. And since people past 65 now represent only about one-fourth of the total number of hospital days, even a large increase in utilization by the elderly would not greatly increase the rate for the total population. If the rate for the elderly, for example, were to increase by 20 percent, a figure which is probably much too high, this would represent an overall increase of something like 5 percent. While this may be a problem in some places, it perhaps does not present the need for a great many more hospital beds.

There is another aspect, of course, of the problem, and that is that in the total continuum of care for which reimbursement can be provided under the two parts of the Medicare program, there are many alternatives to inpatient hospital care. The program covers outpatient diagnostic procedures performed in a hospital, a clinic, or a physician's

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office. It also covers extended care in a nursing home and home health agency services. In addition, of course, the medical insurance part covers physicians' and surgeons' services wherever they are performed. So, to some extent, you have a question of trade-off among various alternative forms of care involved in the question of the impact on inpatient utilization of Medicare.

Another program aspect which will have some effect on utilization is that the extended care benefit is relatively limited. It is conditioned by a post-hospital requirement. That is, an individual must be in a hospital for at least 3 days before the benefits are available, Furthermore, it is limited to 100 days of inpatient extended care.

You have a mixture of variables, and I have not seen a really convincing analysis of the potential effect on utilization or the extent of need for additional hospital beds. It would seem since we begin the program with a large deficit of home health services and too few long-term beds which will qualify, that these are problems which more urgently need to be taken into account in planning for the addition, extension, or modernization of resources.

To participate in the program, providers of services—that is, hospitals, extended care facilities, and home health agencies—will have to meet conditions of participation. These will be designed to assure that payment is not made for care which is recognized to be substandard by the health profession itself. These "standards" or conditions of participation, which are required by the legislation, are being drafted. We have had, incidentally, several task forces within the department staffed by the Public Health Service, Social Security Administration, and the Welfare Administration for about the last 6 months, drafting these conditions. We have had extensive consultation with professional groups and individuals in the drafting, and final approval will come only after they have been submitted to the statutory Health Insurance Benefits Advisory Council which is soon to be appointed.

The method and concepts of payment which are embodied in the Medicare program will favorably influence quality of care. Providers of services will be paid the reasonable cost of the services which they furnish beneficiaries. By providing benefits in this way, the health insurance program will provide financial support for the highest quality of care that can be delivered. A few points from the congressional committee reports on reimbursement may expand on this principle.

These reports stress that what is intended by the law is not some uniform flat rate of reimbursement for inpatient care. What is sought is a payment tailored to the cost of care which might be delivered in an individual situation. This principle of reimbursement then recognizes that the differences in costs from institution to institution generally reflect differences in the quality of care that is being provided by these institutions. So, the payment of the reasonable cost of services is intended to meet actual costs, institution by institution, however widely they may vary from one institution to another—except where they are not reasonable. There is a possibility that an institution's costs may be so substantially out of line with other institutions similar in size, scope of services, and other characteristics, that a question could be raised as to whether they are reasonable.

However, it is anticipated that, after deductibles and coinsurance, the reimbursement would ordinarily meet the full costs of beneficiary care—including those costs attributable to additional staff, additional equipment or other investment intended to improve the quality of care that it is rendering.

The congressional reports further state that in paying reasonable costs the policy should be to reimburse a provider so that an accounting can be made at the end of each cost period for costs actually incurred. So, as prices rise, such a policy will provide for reimbursing providers in terms of what was actually spent—not just agreed to in advance. It is also intended that payment be adequate to encourage the development of the kinds of services required to meet community needs. The program provides support, then, to what has been achieved and makes a continued upgrading possible which will benefit the entire population.

Another point is that the new program, in helping to pay the current operating costs of hospitals and other providers on a full reasonable cost basis, and in relieving these providers of part of their present burden of charity cases, will release funds which will, perhaps, facilitate the construction of additional facilities and the improvement of existing facilities.

Many communities from coast to coast have the basic components necessary to render effective and more comprehensive care to older citizens. With the expectation of assured reimbursement for services to elderly patients, what is lacking in fa-

cilities and organization should now be brought fully into focus for community planning and community action.

Considerable interest has been shown by the professional community in the detailed utilization information and other data on this entire group of some 19 million people which will become available after the program goes into effect next July. These data will not only be available for purposes of administration of the program but also, we expect, will contribute to the body of information available for study and research by persons concerned with the organization, delivery, and financing of health services.

Some significance for hospital planning has been given to the provision in the program which defines inpatient services in terms of two- to four-bedroom accommodations. Some elderly patients now receive "free" medical services in ward accommodations. In lieu thereof, under the new program an increased demand is expected for two- or four-bed accommodations. This aspect of the program could have an effect on the future planning for hospital construction, and perhaps may result in planning for inpatient nursing service and inpatient beds so that within the bounds of good medical practice, the total hospital might be used for any patient regardless of the source of income.

Next, let us consider the administration of the health insurance program. It represents one of the most interesting administrative arrangements that any program has had to face.

Administration will be a shared responsibility between public and private agencies at National, State, and local levels. While the principal administrative responsibility will rest with the Social Security Administration, provision is made for extensive use of private and voluntary agencies. There are links with the insurance community, and there is also a very strong responsibility to be carried by the State health departments. This latter responsibility has to do with the determination of the qualifications of institutions to participate in the program.

The fiscal intermediary and the system of making payments to providers in the program are still other matters to consider. Under the hospital insurance program, groups, or associations of hospitals, or other providers of services can nominate on behalf of their members a public or private agency, or prepayment organization which they wish to have serve as fiscal intermediary between themselves and the Federal Government.

The Secretary will ordinarily enter into agreements with nominated agencies, but will not do so if it will be inconsistent with effective and efficient administration of the program. Normally, you will not find this to be the case. However, where groups of hospitals or individual hospitals have nominated a fiscal intermediary, the Department will have the responsibility to ask some questions about the capacity of this organization to pay bills and about its experience in handling group or prepayment business before deciding whether it can function efficiently and effectively in this capacity for the health insurance program.

If an individual hospital does not want to be a part of this plan—that is, if an association of hospitals has nominated a fiscal intermediary, an individual hospital is not bound by this nomination if it wishes not to be included—it can notify the Secretary and then can have another nomination made, or it may elect to have as a fiscal intermediary some organization that has already entered into an agreement with the Secretary to serve with respect to some other group of providers of services. It is also possible for appropriate groups of providers—for home health agencies, for example, or for State institutions—to have a State agency as their fiscal intermediary.

Under the supplementary medical insurance program, which is the voluntary part of Medicare, the provision is also made for intermediaries, but these are not selected through a nomination process. In this case, the Secretary, or Social Security Administration, acting for the Secretary, will select the intermediaries or carriers, as they are called in the law.

A considerable interest has been expressed by private insurance companies and by the Blue Plans, to serve as intermediaries for the medical insurance part of the program. The decision as to how the country will be divided or how the function will be divided among carriers is another problem that we are facing.

To some extent the responsibilities of a State agency which has a designation to assist us in a program and the responsibilities of fiscal intermediaries will be overlapping. This is because the fiscal intermediaries and carriers, selected under the program, in addition to paying the bills, may also be assigned other functions such as helping the providers apply safeguards against unnecessary utilization. While this is an activity for

which the State agency will also have a responsibility, we think that the activities assigned to State agencies concerned with development and the evaluation of utilization review plans for hospitals and extended care facilities can be generally separated and kept distinct from the kinds of utilization review responsibilities which would ordinarily be carried out by a fiscal intermediary in connection with the payment of individual bills for services.

Another overlapping area results from the fact that the Department may utilize the services of a fiscal intermediary or a State agency to assist the hospitals and extended care facilities to set up and maintain fiscal records and provide accounting support to the extent necessary to qualify as providers and assure that appropriate payments can be made.

In establishing the conditions to be met by providers, we have been directed by the statute to consult with national accrediting bodies and State agencies, national organizations, the American Hospital Association, prepayment organizations, and so forth. The law has established two advisory bodies which are statutory: the Health Insurance Benefits Advisory Council and the National Medical Review Committee.

The Health Insurance Benefits Advisory Council will have 16 members, appointed by the Secretary of Health, Education, and Welfare. This council is required to advise us on administrative regulations and, especially, in formulating conditions of participation for providers. It will be activated in the near future.

The second advisory committee, the National Medical Review Committee, will probably not be organized until somewhat later. Its job will be to study the utilization of hospital and other medical care with a view toward making recommendations about the way covered care and services are used in the program, and to make recommendations for changes. This committee will be representative of organizations and associations of professional people. A majority of the members will be physicians.

If I were to characterize the kind of activity in which we have been most involved in the last couple of months, in fact, during most of the period since Medicare was enacted, it would be that we have been engaged in an intensive period of consultation. We have organized technical study groups to look at various aspects of policy formulation under the program. We have been in touch with the American Hospital Association, the executives of State hospital associations, the American Medical Association, a number of the specialty organizations, the Blue Cross and several individual plans, the Blue Shield, many commercial insurance companies, the Joint Commission on the Accreditation of Hospitals, representatives of nursing groups, nursing homes, and homes for the aged. It has been and will continue to be our intent to expose the proposed policies for operation of the program to such groups before they are put into effect.

Our greatest enemy in the whole affair is time, because if we are to have this vast health insurance apparatus ready to roll by July 1, 1966, then very soon the pieces of the jigsaw will have to fall into place so that we will have an operating organization and process. When the first individual comes into a hospital on July 1, 1966, and puts down his Medicare card, we will have had a State agency certification indicating that the hospital meets the conditions for participation, the hospital will have agreed to provide services under the program, and we will have established the reimbursement mechanisms to pay the claim.

In this connection, we are now working to establish eligibility of the beneficiaries of the program. We have distributed about 15 million pamphlets to social security beneficiaries on our rolls. With this pamphlet we are distributing an election form on which the individual can indicate whether he wants to be covered by the supplementary medical care plan. These forms are beginning to be returned; and while it is a very simple process, the need to obtain responses from 19 million aged persons presents a tremendous workload.

With this direct-mail method to beneficiaries, we will reach about 80 percent of the aged—about 15½ million persons. About a third of the remaining 3½ million aged persons are receiving old-age assistance payments and generally will be reached through State welfare agencies. The rest of the potential beneficiaries under the program will have to get in touch with a social security district office to establish their eligibility and avail themselves of the opportunity to elect coverage under the supplementary medical program.

As an initial step, we also disseminated information to providers of services—to hospitals, to home health agencies, and to potential extended care facilities. We have sent out about 10,000 mailings to hospitals, and about 15,000 mailings to

nursing homes which presumably have a skilled nursing component, and about 1,500 pamphlets to home health agencies. Home health services represent the most limited resource responsive to the benefits available under Medicare.

I would like to comment briefly on the task we see in equipping the State agencies for their role in the program.

Thus far, 43 State governors have designated State agencies to provide for certification of institutions meeting the conditions of participation. As of October 1965, only one agreement had actually been signed between a State agency and the Federal Government. This happened to be Nebraska. However, we have met with 10 or 15 other States; and we are initiating as rapidly as possible discussions with all of the State agencies that have been designated, to put into effect the necessary Federal-State agreement, and then to work with the State to provide the necessary resources so that they can carry out the function that is contemplated under the law.

To organize internally to carry out this function, we are strengthening the staff in our own regional offices. We are adding social security staff to work directly with the State agencies. In addition, the Public Health Service has organized a new division, the Division of Medical Care Administration, and is staffing this Division for support to States on the professional aspects of the Medicare program.

While we are making progress in the 43 States that have already designated agencies, we need to ask some questions about the circumstances in the 9 or 10 States where no agencies have been designated. An essential aspect of the program is that by July 1, 1966, hospitals and home health agencies must be certified to participate. And with the inevitable running of time, were we forced to do so, we would have to work out some sort of Federal arrangement to certify these institutions within a State where no State agency is designated.

We are prepared to finance the full reasonable cost to States for carrying out the task of certification of providers of services, for the necessary consultation to institutions to assist them to qualify for certification, and for a fair share of certain coordination or planning expenses which are related to integrating the health insurance program into the total health fabric of the State. In working out an organization and budget plan, we will need to look at the individual requirements and circumstances in each State. We want to move right ahead with this—full steam ahead because time is running.

In doing so, we believe that we should try to build the Medicare certification of institutions program on the existing program for supervision of institutions ongoing within a State.

In other words, we don't think it would be good public policy or prudent administration to duplicate or parallel activities that are already ongoing in States, or to provide Federal funds which might be used to inaugurate an activity which would substitute for a State activity.

So it is our intent to work with the State agencies in planning to strengthen and to add new dimensions to existing programs in a manner which will provide for certification by July 1 of hospitals and home health agencies, and certifications not later than December 31 of next year for the extended care facilities. In using those kinds of deadlines, I must hasten to add that those are the dates when the benefits must be available. Consequently, we really ought to be talking about a deadline for ourselves for completing the task of certifying hospitals and home health agencies by the first of May. Some providers will require consultation in order to assist them to become certified. We need time for this, and we want to avoid, to the extent possible, anxiety and uncertainty among beneficiaries or on the part of institutions for which certification may be delayed.

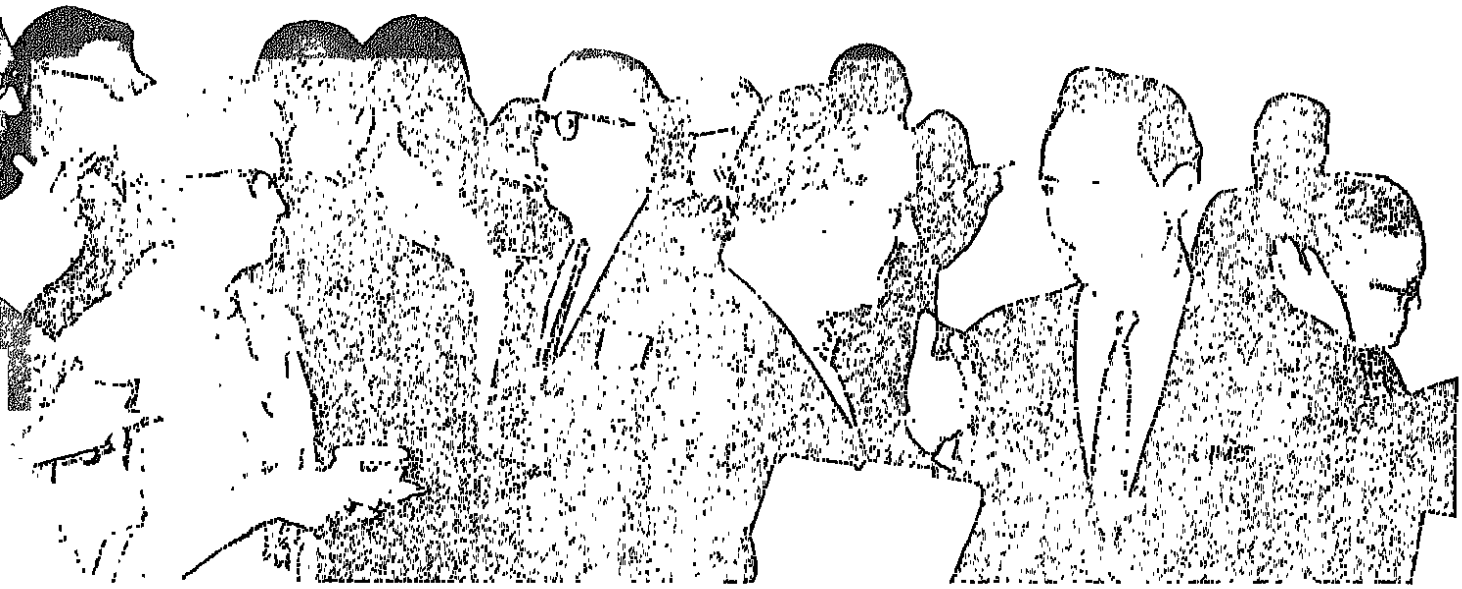
Because of the many facets of the problem of organizing for operation of the program and the time limitations, we may find that we cannot, the first time around, do the full quality job that we and the States would like to do.

In order to assure ourselves that we have the Medicare apparatus ready, we will have to take into account the severe deadlines and move ahead. But for the longer run, we can, together, make the program operate in a fashion which will compliment, strengthen, and improve the general health programs within the States.

We will have, hopefully, within the next month or so, the full set of conditions of participation. These will later have to be approved by the Health Insurance Benefits Advisory Council; but as soon as we have them, they will be released to all the health officers of those State agencies which have been designated so that they can be taken into account in planning.

I would like to say in conclusion that the Medicare program is basically a financing mechanism;

but it is a financing mechanism which we want to operate within the goals and standards and incentives for quality care and for better utilization as they have been developed, or as they may develop in the future. The availability of financing for alternative patterns of health care under the system helps to open the way for community planning to make such care available. Solutions to the problems involved will require an energetic and forward-looking leadership at all levels—local, State, and National. I am confident that, from the point of view of social security, we will be glad to work together with others involved in the most constructive way possible. We want to do a good job in the administration of this law; and we want to be sure that the resources that we provide, or are authorized to provide, are made available in a fashion which will really carry the greatest potential of this health insurance program into reality.



Conferees from States, regions, and headquarters are shown above chatting informally during coffee break on the second day of the conference. . . . Shown at left is the keynote speaker, Dr. Richard Koch, far right, listening attentively as conferees discuss health facility needs of the mentally retarded. . . . Panel participants shown below are, reading left to right, Mr. Allen Menefee, Mr. Luther Stringham, Dr. Wayne Chess, Dr. Martin Meyer, Mrs. Marguerite J. Hastings, Mr. Ronald Almack (moderator), and Dr. Richard Koch. Dr. Harald M. Graning, at far right, presented introductory remarks and presided as chairman over the morning session.

program agenda

Second Day

Friday, October 15, 1965

Program for Constructing Mental Retardation Facilities

KEYNOTE SPEAKER

Richard Koch, M.D.

PANEL PRESENTATION

Formulating State Plans—Developing Projects

MODERATOR

Mr. Ronald B. Almack,
Chief, Community Facilities for the Mentally Retarded Section, State Plans Branch, Division of Hospital and Medical Facilities

Panelists

Wayne A. Chess, Ph. D.
Mr. Luther Stringham
Martin W. Meyer, ED. D.
Mrs. Marguerite J. Hastings
Mr. Allen Menefee

Committee Reports and Recommendations

Moderator Ronald B. Almack introduced the panelists.

Impact of Community Facilities for the Mentally Retarded

Richard Koch, M.D.

IT IS A PRIVILEGE to participate in this meeting with you today because I feel that the bricks and mortar are most important with the exception, of course, of program.

It is always interesting to relate how one entered into the field of mental retardation. You can readily appreciate that there are as yet no training programs for professionals in this field. You simply get in and swim. I can remember the first day that Dr. Parmalee put his hand on my shoulder and said: "Dick, how would you like to run the Mental Retardation Clinic?" I can well remember the disappointment in my heart and wondered: "Have I gone through medical school and pediatric residency program to run a mental retardation project?" I really didn't stop to think about it, and I said, "No, I am thinking of going into private practice."

As you know, doctors aren't interested in money! Anyway, I went into practice and one Sunday after I had made 12 house calls, a mother phoned me and said, "Doctor, my child has been chewing on a green tie and his tongue is green. What should I do?" I thought to myself, "Maybe I will go back and try that job at the hospital." I did, and discovered very quickly that when I looked into the big textbook on pediatrics by Mitchell and Nelson, which is, as you know, the bible of pediatrics, there was nothing on mental retardation. I did find one or two pages on mental deficiency.

I decided that it was about time I tried to find out about this problem. That afternoon, I had a trying experience of telling some young parents that their child was Mongoloid and since they had one Mongoloid child, perhaps they might have another, and perhaps they shouldn't have any more children.

After they shed their tears and I shed mine, I thought to myself that the only way to find out anything about this business is to see a group of children myself and follow them over a period of 10 or 15 years and see what actually happens to them. This turned out to be a kind of a stumble on my part simply due to my ignorance, but it has been the most fascinating thing that has happened to me in my life. It has left me with many convictions about the field of mental retardation, which I hope I can impart to you today.

Table 1 shows the logistical data. We saw these youngsters over the years 1955–59 and have followed them systematically since then.

Over a 10-year period nearly half the children studied, 49.6 percent, are still at home. These children came to us under the age of 1 year with suspected mental retardation on referral by their family physicians.

Notice that a significant percentage have died, 16.1 percent. This is indicative of the severity of the problems of the children that we were dealing with.

Also notice the remarkably small number, 5.6 percent, that we have lost in this particular study. This is because the parents liked us; they felt they were getting a direct service from us; and they also knew they were participating in a long-range study. These are three very powerful motivating factors.

These data show that the community, if it has the facilities, can provide parents with the sustenance they need to take care of their child at

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home. Very few people wish to place their child in a State institution if they can provide the same kind of care in their own home.

Another significant finding is that in following the first 143 infants who came to us in those early years, 35 over the next 10 years turned out to have IQ's of greater than 70. (Table 2.)

Seventy is the technical cutoff point we use for designating a mentally retarded child. This is nearly 25 percent! This means that we as physicians must be extremely careful when evaluating very young infants. In fact, at times we are wrong in our appraisal of what the child's potential may be and sometimes recommend residential care to parents of very young babies who are or appear to be retarded when, indeed, they are not. You can immediately see the tragedy involved in such a mistake.

Table 1

1965 Status of Mentally Retarded Children Studied from 1955-59

Year of study	Total	1965 status				
		Home	Foster	Institution	Dead	Lost
1955	22	9	2	7	3	1
1956	56	22	0	20	10	4
1957	35	20	0	4	8	3
1958	18	12	1	4	1	0
1959	12	8	1	2	1	0
Total		71	4	37	23	8
Percent		49.6	2.8	25.9	16.1	5.6

Table 2

Diagnoses of 35 Children with Normal IQ Who Were Referred To Study as Mentally Retarded

Clinical diagnosis	No	IQ
Postmaternal rubella	1	81
Postnatal infection	1	88
Bilirubin encephalopathy	1	71
Neonatal anoxia	2	80, 82
Phenylketonuria	1	71
Galactosemia	1	94
Hypoglycemia	1	73
Hypothyroidism	4	93, 97, 97, 100
Congenital cerebral defect	2	72, 121
Congenital cerebral defect with cranial anomaly.	2	72, 81
Down's Syndrome	1	95
Encephalopathy associated with prematurity.	7	90, 100, 71, 100, 107, 123, 123
Children with normal IQ (with or without physical handicaps).	11	79, 80, 83, 91, 94, 94, 101, 101, 107, 112, 112

Although institutionalization interferes with the normal parent-child relationship, we are not going to destroy our institutions. There is no question that in a significant number of families, residential care is a very important factor to the parents in helping them manage.

Not only do some of these children have fairly normal IQ's but actually some have turned out to be quite gifted. You will immediately ask, how can a gifted child appear to be mentally retarded as an infant?

It really is shocking to realize I've recommended residental care for a child who eventually turned out to be gifted, but this is a mistake that I hope has helped me mature! When I make a recommendation now, I don't do it lightly.

I want to leave you with the simple moral of this particular issue. When building new facilities for residential care, let's build them in small units so that each child can be treated as an individual.

Let's build facilities where adequate professional people are available for staffing and not where you are scrounging every day to fill 10 positions with 1 person. Let's have 10 people applying for 1 position. This can be done.

When I first started to recruit fellows to work in our child development clinic, I met a stone wall of resistance. It was called a retardation fellowship. It is now called a child development fellowship and it has been a very popular fellowship in our own hospital.

Figure 1 will give you some idea of how communities are responding to this problem. I used to have a rule of thumb that I recommended residential care for every child with an IQ of less than 50 simply because this was what I had been taught in medical school.

Only one child in this study entered a residential center with an IQ of over 50. The majority were institutionalized with IQ's of less than 20. This is a profound degree of retardation so that residential care is a realistic solution for this particular population.

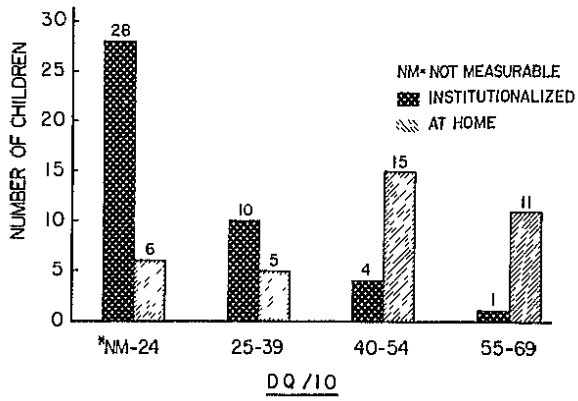

Figure 1. **DQ/IQ distribution of 80 children in State institutions or at home with IQ's of less than 70.**

The one child with an IQ of over 50 who is in a residential center was a severe behavior problem because of a chaotic family situation, in which the parents simply said, "We don't want this child." If he had been placed in a foster home, he perhaps would have done better, but under the social circumstances, residential care was the only solution. It is obvious that the social situation is of great importance.

Figure 2 reveals the course of R. B. He came to us at 6 months of age, at which time he was unable to roll over, stand up, bear weight, or transfer objects. He seemed quite retarded. He was a premature baby who had been a twin birth as well. The first developmental quotient was around 50. I rather foolishly at that time told the parents, "You know, he is quite retarded. You really ought to visit our State institution," and I gave them the usual pep talk I give parents who have to face this problem. These parents though are quite intelligent. They didn't believe everything their doctor told them.

Randy eventually was found to be deaf. This was discovered at age 4. How can one miss deafness until age 4? You simply miss it by not looking for it.

Another important thing in terms of construction. Let's be certain that these diagnostic evaluation centers include facilities for the disciplines that are needed for the care of the retarded: Physicians, social workers, psychologists, nurses, hearing and speech consultants, nutritionists, physiotherapists, etc.

It is extremely important that these children be seen not only by the physician but also by experts in psychological assessment, hearing and speech, family counseling, nursing, followup home visits, and physical therapy. Our own clinic was started with just a physician and social workers. In 1958 we engaged a psychologist. Then we added a hearing-speech consultant, and 2 years ago an educational consultant and a nutritionist.

The population of Los Angeles County is expected to be 25 million by 1975. When we consider the anticipated number of available physicians, it is obvious that we will not have the one-to-one family-doctor relationship that we have had for so many years.

As I look forward to 1984, I see each physician working through other disciplines: Nursing, social work, psychology, nutrition, hearing and speech, etc. These disciplines will carry the day-to-day, one-to-one relationship with families and will utilize the physician for consultation regarding difficult problems.

To dramatize it more clearly, let's take a patient with leukemia: The hematology physicians spend several hours of professional time on the first hospitalization of such a patient talking to the parents about the fact that it is a fatal disease; we do have treatment, but we are not going to cure the patient. One has to begin to work with the parents developing the concept that perhaps this youngster is not going to survive for long.

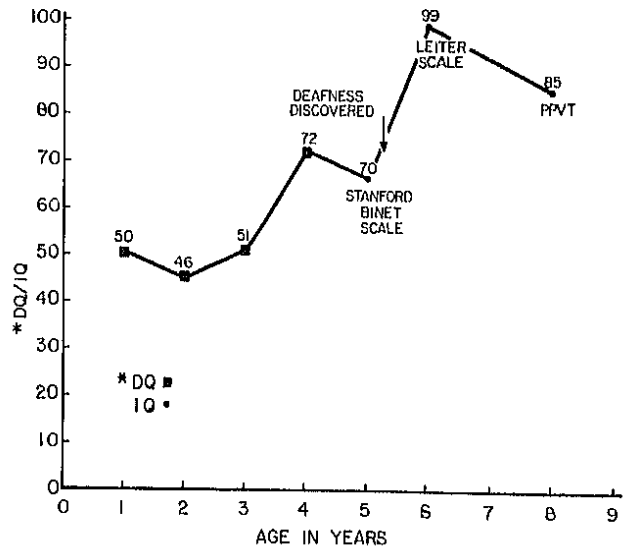

Figure 2. **Course of RB: Spastic quadriplegia, slow development and hearing loss due to kernicterus.**

It is a luxury for the physician to spend this amount of time with the parents. A social worker in consultation with the physician could do the job just as adequately. It isn't a matter any more of having an office and 10 examining rooms where the doctor hastily examines and spends a few mintes with each patient. Instead, conference rooms are needed where inservice training can go on regularly with other professionals who can practice pseudomedicine in a sense.

Figure 3 demonstrates our most significant problem in the last few years. The problem of rubella (german measles) has been a scourge throughout the country. German measles will cause brain damage to the baby if the mother has it during the first 3 or 4 months of the pregnancy. In fact, we are finding that even if the mother has German measles 6 weeks before conception, she may still carry the virus and infect the fetus.

The child referred to in figure 3 was seen first at age 3 months. The local physician had already recommended residential care to the parents. When I saw him, he had bilateral ocular cataracts, a heart murmur, and appeared malnourished. He didn't smile. He didn't reach out and grasp or roll over. I supported the recommendation for eventual residential care. The parents were young and unfortunately in our State we have a 3-year waiting list for residential care. During that period, we had the social worker and public health nurse talk with the parents and help them work with the child.

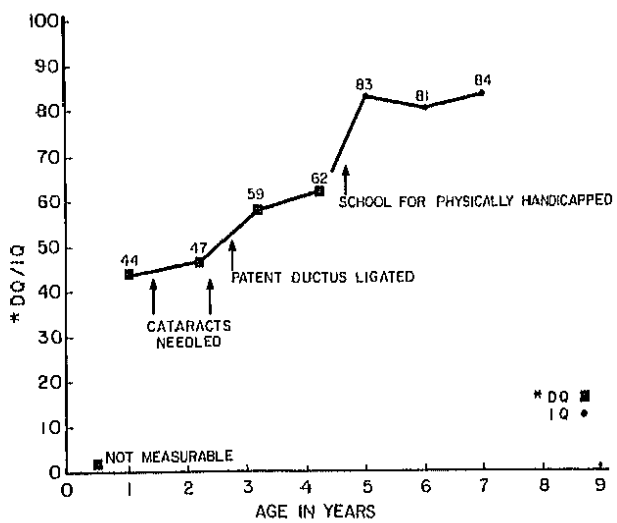

Figure 3. **Progress of boy with postmaternal rubella syndrome.**

The mother subsequently became pregnant and had a healthy baby. As the child began to grow, the question came up as to what could be done for this baby's eyes. We referred him to the ophthalmologist, who said, "Now, usually these babies are so retarded it doesn't do any good to do anything with the cataracts." At that time, I had had some interesting experiences with handicapped children with eye problems and so I urged him to go ahead and needle the cataracts, and the youngster developed some sight.

We also asked the cardiologist to ligate a patent ductus arteriosus, and this made a tremendous improvement in the baby's nutrition.

The parents carried through with recommendations for this particular child, and they had enough conviction to feel they should do for him what they would do for any of their children.

You can see the amount of medical care and participation here which was supplemented by the other disciplines of social work, nutrition, etc., in helping these parents work with this problem.

I am proud to say this boy is in a public school program at the present time, and I look for him to be self-supporting in some manner of work. Isn't this better than if he had had parents who were unwilling to keep him at home?

Again, in terms of individuals with IQ's of 80, we must look at people as people, and begin to appreciate what families can do for their children when given the right kind of community support.

This experience at Children's Hospital led me to wonder how we could institute similar services in other States. All over the country today retarded children are being seen in physician's offices, and a lifelong prognosis is being made on the basis of an observation ranging from one-half hour to one hour. This approach is unrealistic for the retarded child.

It seems that health departments would be a logical vehicle to begin to develop services for the retarded child since they have a health officer, social workers, and public health nurses. Generally, health departments are not overly active in mental retardation. Why aren't they? They see retarded children in their well-baby clinics. Why isn't more being done from a public health point of view? No matter how you look at it, mental retardation is a public health problem. It affects 3 percent of our population and is a chronic lifelong disability.

I got quite a mixed reception from the health officers when I presented this proposal to them. In

fact, one of them said to me: "Now, Dick, I think you do a terrific job at the hospital, but we can't do this sort of thing out in the health departments. The private physicians wouldn't let us." I simply rejoined by saying, "Let's give it a try. We can go to the medical society together and put this across." And we did.

Local health department participation required approval of the board of supervisors. We didn't have any trouble selling this program to the board. It turned out that the head of the board of supervisors had a retarded child. This became a very important lesson for me. I learned that the force that lies in this program is in the parents group movement. I decided to join that movement, and I became the chairman of one of their committees, and finally one of their vice presidents, and this year, I am the president of the California Council for Retarded Children.

It has been an exciting experience working with this volunteer organization. I have seen them get things done that you and I as professionals, simply could not accomplish. The parents group movement is one of the most powerful forces that has happened in the field of retardation. The quality and the support that can be obtained from this movement demand your recognition and support.

This year in California they were able to pass four very important pieces of legislation that went through the assembly, through the senate, and on to the Governor's desk for his signature. They were pieces of legislation considered for 15 years before that, without any success.

In Californa, we have developed clinics for the retarded in 10 of the southern California health departments. There are 13 southern California counties which contain 60 percent of the State's population.

One doesn't have to build a big building for a clinic, but we need construction money for buildings to house services that can help parents take care of their retarded children in the community. We need workshops. We need residential care. We need training classes.

Title 1, Part C, of Public Law 88–164 provides us construction money. Unfortunately, we didn't get enough of it. In our State, we could have spent five times the amount of money in title 1 that we actually were entitled to. Therefore, I would recommend that appropriations for Title 1 of the construction legislation be increased substantially. We really need more funds to help us put these programs over and help parents give their children the services they need.

How does this affect what one does in a health department? Typically our clinics are held in a single large room. The most important components are the professional people with the skills to deal with this problem. The clinics are also used as a vehicle for professional education.

Everybody involved in the care of the child comes to these clinics—representatives of welfare, the crippled childrens' and united cerebral palsy organizations, the probation officer, the educator, the hearing and speech people, etc. All of the professionals who attend will help implement, in an organized manner, the recommendations of the diagnostic team to the parents.

You may be thinking, "California is cosmopolitan, but how about my State? How about way up in Leadville, Colo.?" Well, California has a few rural areas left. For example, Markleeville, Calif., hasn't changed much since 1898. It has a population of about 600 and still has a few 4-footed animals for transportation. We have held clinics in Alpine, Mono, and Inyo counties. All are rural. This type of project can stimulate local people in the rural areas to help themselves.

What goes into mental retardation? This is one of its virtues in a way, and yet one of its biggest problems. Mental retardation belongs to everyone. It doesn't belong to any one discipline. It doesn't belong to pediatrics any more than it does to neurology, any more than it does to psychiatry. It belongs to all the professions across the board. Mental retardation should not be isolated. *Services for retarded children should be integrated into the services for all children in the community.*

Stop and think of what you enjoy most. Is it money? Your automobile? I don't think so, I think it is your family: What your children are doing, and so on. This is also true for retarded individuals. They enjoy family life as much as you do. This is often overlooked because the individual is retarded.

Before closing I must bring up the problem of birth control for our retarded adults living in the community.

In a recent family we studied, 5 of 10 children were mentally retarded. The mother is quite limited and their first three children were retarded. The family was unable to obtain birth-control information in their local health department. Subsequently they have had seven more children.

They still are looking for some help in terms of birth control, and they can't get it.

I think that society has to recognize that we know there are families in which the genetic inheritance is such that they really shouldn't have more children and must facilitate the spread of essential knowledge in our communities.

There are diseases in which we can predict with certainty now that one in four of the children will be affected, say, with phenylketonuria. When we know this, it is society's obligation to help such parents with proper birth-control knowledge and procedures.

The modern clinic providing mental retardation services in the future should be closely integrated with health department services, with family care and planning services readily accessible to parents.

Formulating State Plans-Developing Projects

Wayne A. Chess, Ph. D.

DURING THE LAST 2 YEARS, planning has been carried on at a hectic pace in Ohio, and I am sure this is true for the entire Nation. It has been a necessary step and a very rewarding one. In Ohio, the planning phase has had a real impact on the development of mental retardation facilities, especially at the community level.

My assignment on this panel is to review some of our experiences in Ohio in moving from planning to implementation. Before doing this, let me review some of the pertinent administrative arrangements and responsibilities in Ohio as they apply to programing for the mentally retarded.

First of all, the Department of Mental Hygiene and Correction is responsible for the institutional programs for the mentally retarded. Through a matching arrangement, the department can also assist counties in meeting the operational costs of workshops and educational and training programs for those mentally retarded with IQ's under 50.

Ohio is one of the few States where the responsibility for the educational programs for the mentally retarded with IQ's of 50 and under is vested with the Mental Health Authority as opposed to the educational authority. The local administration of these educational and workshop programs, however, is vested in the county government.

Our slow-learner programs, that is children with IQ's in the 50 to 70 range, are the responsibility of local boards of education. The Department of Mental Hygiene has no responsibility for these children.

Second, Ohio counties have the authority to tax themselves for purposes of constructing and operating facilities for the mentally retarded with IQ's under 50.

Third, the Department of Mental Hygiene and Correction in Ohio was designated as the sole agency to administer the comprehensive planning programs for both mental health and mental retardation.

Fourth, the Department of Mental Hygiene and Correction was designated as the sole agency to administer the two construction program, Title I, Part C, and Title II of Public Law 88-164.

Fifth, within the Department of Mental Hygiene and Correction, the Bureau of Planning and Grants is responsible for providing the staff service to carry out the comprehensive mental health and mental retardation planning projects, and for administering the two construction programs.

Now, just a couple of comments on some

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important principles in planning and its implementation.

First, there is value in having the planning and implementation functions closely linked administratively. Conceptually, planning and implementation should be viewed as a single process. This was the rationale for the particular administrative arrangements that we have established.

Second, any planning operation needs to be vitally related to the specific objectives; the more specific, the better. In Ohio the Mental Retardation Study was directed toward giving visibility to the problem, creating interest, and moving communities toward action programs.

We decided that if we wanted to encourage the future development of community-based programs for the retarded, it was of fundamental importance to involve the community in the process in the very beginning.

Mental retardation planning and mental health planning were combined in Ohio. We had a single planning structure and a single staff. We protected the visibility of both of these efforts through establishing separate study committees and through staff assignments. By combining these two planning programs, the base of the study was broadened both operationally and fiscally. We were able to involve more than 3,000 Ohionians in a direct planning effort. This would not have been possible, I feel, had these planning projects not been combined.

In this way we were able to encourage and influence planning at the community level. We had a total staff of 20 professionals so that we were able to provide some unity to the operation and a measure of staff service to assist planning activities at the local level.

We had no problems of any consequence in combining these two studies. A more unified citizens' movement has resulted: One that will work on behalf of the programs for the mentally ill and mentally retarded—a group that recognizes the differences between these two problem areas and that in unity there is strength.

By administratively linking the planning and implementing functions within a single State agency and with one staff, we were able to use the Federal carat in the form of construction monies under Public Law 88–164 as the incentive to get some real work out of our Citizens' Committee. This committee is the broadly representative group that was responsible for guiding the development of the two planning projects.

Determining the need for and working toward the development of mental retardation facilities were only two facets of their total planning effort, but they were important facets. It gave real meaning to their planning activities.

Here community groups had a means for implementing some of their efforts.

Too frequently, long-range planning involving citizen groups in the field of health and welfare has been an exercise in futility. We sought a planning operation that would produce tangible results, and an operation that would provide a satisfying experience to community leaders who were giving of their valuable time.

The State construction plan prepared by the Department of Mental Hygiene and Correction was the embodiment of a part of the Citizens' Committee's work. All of the recommendations embodied in the State construction plan had previously been considered by regional planning committees and the State Citizens' Committee.

Thus, the State construction planning became the instrument by which the State agency implements a portion of the work of the Citizens' Committee. This close working relationship between the Citizens' Committee and the Department of Mental Hygiene and Correction was of fundamental importance. This kind of linkage of effort greatly accelerated our planning operation generally and the submission of the State plan.

Further, the applicants for construction assistance for mental retardation centers as well as for mental health centers, for the most part, have been generated out of the planning process. In several cases the submission and passage of county bond issues were a direct result of people working on the planning project. I would like to emphasize the point noted by Dr. Koch of the importance of seeking the help of parent groups in operations of this type. We sought very early in Ohio to involve the Ohio Association for Retarded Children. Here we gave them an instrument to work with, a direct linkage with the State agency, and also the incentive of the monies under Title I, Part C, and they really went to work.

In all cases, those applicants for Public Law 88–164 monies had to go to the planning committees in their respective areas to secure certification that their proposed facilities were in keeping with needs of the area and consistent with the comprehensive planning activities.

The State agency incorporated such a certification as a part of its preliminary application

procedures. In this way it provided integrity to the planning operation and literally put teeth into the work of the Citizens' Committee.

In Ohio, we have had little problem in raising the non-Federal share of the construction cost. Our problem is that the number of projects we would like to support requires far more Federal aid than is now available under Title I, Part C, Public Law 88–164.

The five applicants programed to receive construction assistance from fiscal 1965 monies include one voluntary agency and four counties. The cost of the projects will be in excess of $2 million. All will be new facilities, four will be multipurpose facilities. They will house training, educational, and workshop programs. In some cases, they will contain diagnostic clinics, however, some of the diagnostic services will be shared with our mental health clinics and our general hospitals.

This sharing of services was another one of the reasons for combining these two planning operations.

In each case, the facilities that are being programed are but a phase in the development of comprehensive programs for the retarded in the area.

In all cases, part I of the application procedures has been completed and in four of the five cases, the part I has been submitted to the regional office for informal review.

A major concern in Ohio shared by both mental health and mental retardation interests is that more money is needed under Title I, Part C, Public Law 88–164. This is one of the recommendations coming from our Citizens' Committee.

During the planning operation and in the preparation of the State construction plan, we estimate that about 18 percent of the need for specialized community facilities for the mentally retarded has been met in Ohio. We have a long way to go in our efforts to provide adequate facilities for the mentally retarded.

To cite the handwriting on the wall in Ohio, we are now beginning to process requests for Federal construction assistance available in fiscal 1966, under title I, part C. We estimate the total cost of these projects to be $3 million. These are all community facilities. The applicants are counties and voluntary agencies. Our allocation under this title next year will be $576,376. It is therefore quite apparent that there is a real need for Congress to consider increasing the assistance under this title to a more realistic level.

The incentive provided by the Federal legislation has given a tremendous lift to these community efforts to supply adequate facilities for the retarded. My concern is that the extremely modest amount of Federal money made available for this program may frustrate this incentive.

From Plan to Project

Martin W. Meyer, Ed.D.

IN INDIANA, as in many other States, the legal definition of mental health includes mental retardation, epilepsy, narcotic addiction, and alcoholism. When we started planning for mental health facilities in July 1963 we quite naturally included the needs for services to the mentally retarded.

Planning for mental health and mental retardation facilities was well underway when we applied for a planning grant for mental retardation services. The mental retardation grant, even though short on dollars, helped considerably in the total planning effort. Starting early with little or no guidelines concerning planning for mental-retardation services, both programs were organized and, in large measure, carried out together. We know now that while these programs are very closely related and many aspects of planning should be carried out together, there are many differences in needs which require individual or separate planning. Fortunately, we had time to sepa-

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rate the final reports and to produce a separate plan for mental retardation. While many aspects of the plan are identical to the mental health plan, the mental retardation plan now stands on its own as an individual document.

The Indiana Department of Mental Health has the responsibility for developing both the mental health and mental retardation plans. Specifically, the Division of Planning and Evaluation is the planning authority.

The Indiana State Board of Health has been designated by the Governor as the State agency responsible for both the mental retardation and mental health State construction plans. A single advisory committee will serve the Hill-Burton program as well as the mental health and mental retardation program. This appears to be an excellent arrangement with the State Board of Health utilizing its expertise in supervising the construction of facilities and the State Department of Mental Health utilizing its expertise in program services.

To date, this has worked extremely well with one agency handling program and program consultation and the other now gearing up for the supervision of the construction program.

The planning effort in Indiana has been largely decentralized with the development of 12 regional planning committees. Each committee has broad membership from governmental agencies, voluntary agencies, and professional organizations. Contracts were entered into with local agencies responsible for community planning and health and welfare services. These agencies, most often community service councils or health and welfare councils, provided staff assistance to the regional committees and considerable professional know-how about the local community and medical and welfare needs.

Our contracts with local planning agencies required them to conduct extensive surveys, using survey instruments provided by our office. In this way we were able to have overall consistency in data gathering, but an individualistic approach through the utilization of local planning agencies. We have gone to the people and have insisted that they take the major responsibility for planning to meet the needs of the mentally retarded. While we relied heavily on the local associations for retarded children, we did not want to make this their exclusive project. We tried to broaden the local base for support by bringing in many citizens, outstanding leaders in the community, who have never been involved in mental retardation services. It was our desire to garner their interests through a personal involvment in both the planning process and in the determination of practical means to implement recommendations. While we undoubtedly lacked a certain amount of sophistication in the early days of planning through local citizens, with careful guidance and counseling, skills increased and we are, by and large, satisfied with the first year's plans coming from each of our 12 regions. We are certain that as years go on, sufficient expertise will develop among the lay planning committees, to assure the fullest development of services to the retarded.

We have had a thorough statewide involvement. I think it is interesting to note that Ohio, with a population of about twice that of Indiana had approximately 3,000 citizens participating and we had approximately 1,500 citizens. This approach is undoubtedly unique in planning for the social welfare needs of people—1,500 citizens in the State of Indiana actively involved in the survey process and, undoubtedly more important, in the implementation process. They were, for the most part, seeing this problem as it really exists. They saw first hand the tremendous impact mental retardation has on the indivdual and families so afflicted. This impact was so great, that while we were only halfway through the planning process when our general assembly met, important legislation was enacted which is going to have far-reaching effects in the State of Indiana.

While we did not want to anticipate the results of the planning effort and ask the legislature for legislation to meet needs that we could not fully document through incomplete planning, we did succeed in getting funds appropriated for matching the Federal construction funds and enabling legislation for local communities to raise a local share. Specifically, we were able to get a 2-cent increase on the cigarette tax for the months of May and June 1965, which will net us approximately $2.5 million dollars. This will allow the State to provide 25 percent of the cost of constructing mental health centers and mental retardation facilities. Additionally, the legislature passed a bill permitting local counties to tax property up to 10 cents on each $100 of valuation, to provide local funds for both the construction and operation of mental health centers and mental retardation facilities. With previous legislation for the operation of mental health clinics and mental retardation services, we now have enabling legislation for

local government to participate up to 17 cents on each $100 of property valuation. With this legislation we have been able to establish a participation ratio which will be 50 percent Federal funds, 25 percent State funds, and 25 percent local funds.

While this is a most difficult tax to enact, in our State as in many other States, tax on property is the only source of local revenue. We have been surprised by the number of communities which have actually enacted this legislation on the first go around, having so little time to do this.

The law didn't go into effect until July 1, 1965, and local tax commissioners were working on their budgets at that time. Sufficient interest and pressure had to be mobilized by the middle of August to get this included in the next calendar year's tax rate, so you can see that time was at a premium. Nevertheless, several communities were able to get this levy included in their tax rate and to utilize this as their local source of matching funds.

Within 2 weeks after we announced that applications were open for construction projects, we had 5 applications for projects totaling better than $3 million. The Federal 50 percent matching share would have to be $1,500,000 if we were to fund these projects. Our total allotment for the first 2 years is less than $500,000. We are, as you can imagine, very much worried about what this is going to do to the morale of those who have struggled so hard to develop eligible projects. For the past 2 years we have traveled extensively throughout the State as part of our planning efforts. We have offered $3 of State and Federal funds for every $1 which could be raised at the local level for projects determined through the local planning programs. Let's face it, this is an excellent incentive, $3 for every $1 raised locally. This undoubtedly had something to do with the opening of the floodgates. Regardless of what caused this avalanche of applications, we have it and now must make some arrangements to phase some of these projects over a longer period of time.

This is just the beginning. Next year we may well see 10 applications for projects and this may grow to 15 or 20 in the following year. I would say that probably every region within our State is now working on a proposal to their local county commissioners for the enactment of a local tax so they can qualify for State and Federal funds.

Not all of the local money has been raised through property tax. One community has raised their funds through local subscription. Another, the American Baptist Home, Inc., a national organization representing the Baptist Church, has raised funds through church membership. This organization has selected Indiana for its first demonstration project on a combination residential and day care program for the mentally retarded. This group has been very successful in organizing retirement homes and feels that it can be equally successful in establishing services for the mentally retarded. If successful, the organization will undoubtedly establish a nationwide network of mental retardation facilities.

The need is there. Interest is rising far beyond our fondest imagination. Our biggest concern at the moment is money. We hope that we will not have to wait until the 4-year program has run its full course before additional Federal legislation provides the continuation of this program.

I know that Indiana and Ohio are not unique with this overwhelming positive reaction to the program. I know that other States are experiencing the same phenomenon. Interest is running high. I hope that we can strike before there is a letdown. Additional funds from the Federal Government appears to be the only answer. I think that there may well be a time in the future when a combination of local community effort and State support will be enough to raise the necessary funds for extensive community services. However, for today, the people have been sold on this as a Federal program to help provide these vital services. I truly hope that every effort will be made to be sure that the necessary funds are forthcoming while interest and need are running so very high.

Gaining Community Support

Mr. Luther Stringham

IT IS SOMEWHAT difficult to generalize on the subject, "Gaining Community Support." The preceding speakers have talked about the situations encountered in their States. Their experiences have been quite different, as you heard, even for States which were adjacent. So I am sure that you may be thinking that "What may be all right for California or Ohio won't necessarily work in my State."

Obviously, the task of gaining community support in Alabama, or Nevada, or Ohio, or in some other State is not precisely the same. I'm going to talk more generally, therefore, about some principles that we follow at the National Association for Retarded Children (NARC), even though I know that they are not applicable to every State. As my contribution to this panel I will focus my remarks on the NARC—its membership, its organization, and how we meet some of the problems of relating to government and to community agencies.

The National Association for Retarded Children is now one of the larger of the national volunteer agencies. It was organized in 1950, and since that time, it has grown very rapidly and now has affiliates in every State. Altogether they number 1,034 units. We have State associations in every State except Alaska.

Twenty-four of our State associations are "State Member Units." In general, they are the stronger State associations, and they perform certain administrative and other tasks for the national association. However, for practical purposes all State associations are regarded as important elements of our total organization. Thus, we are well represented in all parts of the country and are working toward strengthening our State associations.

At present we have about 100,000 members—a rapid increase since 1950. This growth is expected to continue.

Though great progress has been made, we are not satisfied with regard to the organization's geographic coverage or the strength of our units. Nor are we content with the size or the composition of our membership, even though it is quite impressive when you think of having 100,000 people committed to a particular problem. We recognize that our organization is comprised primarily of white parents of the more severely retarded.

While there are important segments of the population that are not as adequately represented by our organization as we would like, it is to the credit of the founders of the national association that it is written into our constitution that we are concerned with *all* retarded children, everywhere, regardless of their race. We serve as the representative of all of the retarded.

Our organization is often referred to as a "parent organization" since a large percentage of the membership has a personal involvement. These members include parents, grandparents, brothers, and sisters of retarded persons. But we also have as members a growing number of persons, like Dr. Koch, who has a great professional commitment to the problem of mental retardation. We have more special education teachers, persons involved in residential care, religious nurture, and health and other professionals joining with us in increasing numbers.

We estimate about 20 percent of our membership includes persons other than the parents of retarded children themselves. Some say that it is too bad to have our organization so largely based on persons who have a personal commitment, but I take a somewhat different view about this. In the first place, mental retardation is no respecter of professional or economic status. Consequently, in getting a job done, we find that it can be assigned almost invariably to some distinguished person who has a more or less immediate concern with the problem.

This person might be the President or the

Mr. Stringham is Executive Director, National Association for Retarded Children, Inc., New York, N.Y.

Vice President of the United States, some distinguished Member of Congress, a physician, or religious leader, and so forth.

The problem of mental retardation is so prevalent that we usually can find distinguished business and professional people who have an immediate involvement in helping to gain community support. True, some of these people are emotionally involved; yet I have observed that, whenever the heart, pocketbook, business, family, or some other vital thing is concerned, the person becomes somewhat emotional whoever he is. Have you not observed that frequently feelings run pretty high in political campaigns, strikes, PTA meetings, and various other aspects of our life? Perhaps being emotionally involved is not bad after all.

If emotionalism becomes irrationality, that of course, is wrong. However, in the many contacts I have had with our volunteers I am quite surprised at the calmness, steadfastness, and deliberateness with which the leaders of NARC and of our State and local units go about their business of planning programs and of relating to government agencies, to legislatures, and to other organizations.

Next, let us examine the role of a voluntary organization, since it appears to be changing very rapidly these days. Some of the voluntary organization people with whom I come in contact are concerned about the expansion of governmental programs, both Federal and State. They ask, "What is going to be left for us?" They wonder if, in time, everything may not be taken over by the Federal Government.

At NARC we do not see current trends so much as a threat but as a challenge. Of course we do not believe that all activities should come under governmental aegis. Yet it is NARC's official policy that our State and local units should not, by and large, operate facilities and run programs. Our responsibility is to see that other elements within the community take over *their* responsibilities in establishing and operating programs.

In the area of education, public and private education agencies should measure up to their responsibilities. Similarly, in the fields of vocational rehabilitation and health we do not see ourselves as being threatened by some of those who exercise their proper functions. Rather, we visualize that we can be of significant help in the *implementation* of the Federal programs. We have been working with Dr. Graning, Allen Menefee, and many others, in trying to do what we can to help promote their programs. We want to be a source of strength to those administering the programs.

Nevertheless, we do not intend to become entirely subordinate to the Federal and State people who are involved in a particular activity. Actually, we feel that we are one of the sources of strength in a democracy. We are a link between the people and their needs, and the people who are responsible for carrying out those needs through governmental programs. We are mindful of the fact that it is deep in the tradition of this Nation that, whenever necessary, it is not only the right but the duty of the people to take action that will insure that the Government is responsive to the Nation's needs.

We have, in certain instances, had head-on clashes with what we regard as bureaucratic positions that were not defensible and which were not in keeping with the times. By and large, however, our overt clashes with authority are not very large in number. Mostly, we work professionally, sympathetically, and cooperatively with most State agencies. We hope this will continue to improve as a result of the strengthening of many of our State organizations.

Many State associations for retarded children have been gaining in strength, but not all yet match Dr. Koch's California Council for Retarded Children, of which he is president. It has three professional people on the staff. Other States having particularly strong associations are Minnesota, Michigan, and New York, where the staff includes several top-flight professional people.

There are executive directors in about two-thirds of the States, and we hope within 2 or 3 years there will be professionally competent executive directors in each of our State associations.

We are striving for a high level of professionalism. For example, I have with me two of our most recent publications, one relating to the employment of the mentally retarded with a caption on the cover, "This isn't kindness. This is business. They are good workers and they are a good investment." Here, too, is our 1965 annual report that has just come off the press.

Next, let us look at our future objectives. We feel that as progress is made in education, in vocational rehabilitation, and in the medical treatment of the mentally retarded, that more and more children and adults will be able to live within the communities and be either partially or almost entirely self-sufficient.

We are learning more about how to test for the

residual capacities that retarded persons have, so we are not so misled by the single IQ number. We are learning better that, though one faculty may be very low, such as the ability to verbalize (which means they get very poor grades in school), another faculty, such as manual dexterity, is good. With proper care the stronger abilities can be further strengthened enabling many more children and adults to approach more nearly a fully independent life.

This does not mean that there are not going to be many who will remain dependent. In fact, there will be an increasing number of the more severely retarded, for a while at least. Consequently, there must be major programs of institutional care. It does mean, however, that we are going to have to think constructively about new forms of community living, new kinds of facilities that will enable a person who can almost but not quite get along in the community, to have a place where he can go, where his money problems, social life, and recreational activities are better supervised.

We are doing a lot to prepare the mentally retarded for employment, but we are also discovering that the 8 hours of the day that he is on the job is often not as important to living in the community as the 16 hours away from the job.

We need more places of sheltered employment for persons who cannot fully work under competitive conditions.

In conclusion, I would like to give you our view of the place of the retarded individual in the broad spectrum of social services. This is at the core of some of the acid discussion that has gone on as to the relationship of mental retardation to mental health programs.

I would like for you to visualize two persons: one with an IQ of 100 and the other with an IQ of 65. We think it is obvious that as these two persons go through life, they need a whole variety of different kinds of attention—medical, educational, vocational, employment, placement, and so forth. From the cradle to the grave they need services. Now the primary reason for the differences in services for these two individuals is that society plans and provides services, by and large, for the *norm*, for the person with 100 IQ. Society has not, generally speaking, adjusted services to take care of the needs of the one with the 65 IQ. The teacher and even the physician think more in terms of the 100 IQ than the 65; so does the employer. Our job consequently is to make sure that all services are properly adapted. We try to help educate all of the professions—ministers, vocational rehabilitation counselors, teachers, and health personnel—to take their share of this responsibility. In providing the broad spectrum of services, all are needed, not just the mental health authority.

Also, we feel that among these professions there are no second-class citizens. They all have a key role, and this means that we want the mental health authority, the employment services, the school—all of them—to do their share. Moreover, we are not going to engage in fruitless efforts to try to have all of them placed under one agency or another. Obviously, they should not be.

Finally, a word about prevention. It is very important for us to remember that in all our efforts we are trying not only to secure services to the retarded, but also to bring about a reduction in the incidence and severity of this tragic problem. We are greatly concerned, therefore, about improving maternal and child health, ameliorating the effects of cultural deprivation, and promoting preschool programs, genetic counseling, and all the other kinds of tests and activities which will reduce the magnitude of this problem. To an increasing degree we are devoting our attention to these matters of prevention.

Enlisting Support of Professional Groups

Mrs. Marguerite J. Hastings

WHILE THE CONSTRUCTION of facilities is one of the primary interests of many in this audience, I am sure that we are all aware that it will be the personnel who will give life to the services and programs within them. We are all grateful for the recent gains which have been made from the standpoint of obtaining Federal construction aid. Unfortunately, however, the Federal legislation thus far enacted does not give sufficient recognition to the financial support needed to fill our personnel shortages. This is a need which is most urgent and every effort should be made to make this known to our Congress. Just as the Federal Government has provided seed money for construction, in like manner funds should be made available so that a sufficient number of personnel can be employed at adequate salaries. Construction and adequate personnel need to be integral parts of our planning.

All of this reminds me of the remarks of the chairman of one of the task forces in our Comprehensive Plan in Maryland, which seems apropos to this problem. At the end of a very serious day, he expressed his concern over not having accomplished more and wondered why the professionals could not simplify the giving of information on mental retardation and the programs in it to the various professions, and the special interests within the professions. He explained that it was all he could do to keep up with the reading in his own special interest area. He suggested that a "show and tell" approach be used in a 1-day meeting—similar to the programs used for children in school.

An oversimplified approach has merit. It contains the components we need to recognize when we try to enlist the support of the many professions and many specialties within the professions. Basic elements to consider in using such an approach are: (1) the child has a *need* to present a story to the class; (2) the child picks a story in which he is interested; and (3) he has to learn to present it in a manner which will involve the class in a way so that it will be interesting and have meaning to other class members.

In the same way, we have a need (1) to present our program to the community; (2) to pick a program which we are focusing on at a particular time; and (3) to find a way to present this program so that we will evoke the interest and involve the professional to the point that he will either support the program professionally or become an active part of the program—whichever role we are looking for him to take at the time.

There are three separate, but equally essential, times when it is necessary that we involve the professionals if we are to improve both the quality and quantity of personnel in this field and create a greater awareness of the needs of the mentally retarded. First, we need to enlist the support of university and college personnel at both the undergraduate and graduate levels to include curriculum content in mental retardation whenever possible. Second, we need to involve professional personnel at the time when we are planning new programs— not when the planning is complete; and third, we need to explain programs and future needs of programs to the professional at the time he comes to us asking help in planning for a specific retardate in whom he is interested.

Involvement of University and College Personnel

If we are to increase the supply of personnel in this field, we must express our needs for the

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inclusion of mental retardation content into student programs before these students have made a final commitment to their future specialty. In so doing, we must recognize that with this request goes the responsibility that we may be asked to participate in giving some of the class content, provide the use of our agency or institution for class visits and, in many instances, try to build an opportunity for summer and part-time employment so there can be real exposure and involvement in order to have these people interested in mental retardation.

There was a time when this was a difficult selling job to a college or university, but many things have come about to change this. No longer do you expect raised eyebrows from your colleagues when you say you work with the mentally retarded. Contrary to this, it has become almost a status symbol in some areas to express an interest in the field. Then, too, the many scholarships and fellowships make it easier for the teachers and you to interest students in specializing in this field. Further, let us remind ourselves that student training has much to offer any agency. They will, first of all, keep your agency stimulated by their new thoughts and new approaches; and you will have to maintain a quality program if you are to be an acceptable field agency for training. Finally, and most important, if you have presented your program in an interesting and challenging manner, you have a good prospect for an employee when he has finished his training. But if he doesn't come to you as an employee, you can be assured that whatever field he chooses he will be more alert and sensitive to the needs of any retardate he may serve. He will also be more knowledgeable as to the resources that should be available to meet the needs of the retarded from the many agencies and many professions.

The American Association on Mental Deficiency—now in its 89th year—is a multidiscipline group which has moved in this area to enlist the support of professional personnel by holding workshops with schools and professional groups in psychology, research, social work, etc., to try to increase the interest of the various professions in mental retardation at both graduate and undergraduate levels. Our own panel member, Dr. Koch, conducted a workshop this past year on more recent medical information in the field. Workshops have also been held in nursing, physical therapy, vocational rehabilitation and other specialties. In the same manner, the various professions in A.A.M.D. are working to bring about a closer liaison with other professional groups such as American Medical Association, American Psychiatric Association, and Council for Exceptional Children. And here, let me add that the president, the various vice presidents, and the Office of the Executive Director, Dr. John Noone in Washington, will be glad to offer consultation in their areas of special competence or put you in touch with several in whatever State you may represent.

Involvement in Planning

The involvement of other professionals in planning new programs is an area that, until the time of our comprehensive planning, has failed miserably. For often we sit in our so-called ivory towers and sweat and plan in isolation and then wonder why when we ask the professional to participate, he shows a reluctance or outright unwillingness. Wouldn't it be simpler although a little more time consuming, to ask him to meet with you? Let him and the rest of the group that you will *need* to *implement* your idea know what you have in mind. Ask for their suggestions and reactions, being sure to listen and hear what they have to say. They can tell you many things that may be unique to their area. You may have suggestions of other personnel they may not have considered. Most often, I believe, you will find that you will leave with your idea slightly changed but, most important, when you leave they will have participated, will have become involved, and if they have been sold, your idea will no longer be yours alone but theirs. Frequently, if you hear the idea presented by them later, you may even begin to wonder if you had a part in its original presentation, but when this happens, then you can be sure you have enlisted their support.

Explaining Programs

One of the most productive methods of enlisting the support of professional personnel—although time consuming—is that of explaining programs in response to a specific request.

At the time a physician calls asking for help for a child (and perhaps for an upset family in addition) it is an opportune time to help him know the resources that may be available. If you can offer him help in meeting the needs of the family and child with whom he already has a relationship,

you can generally expect that you have won his support. Once this doctor understands and accepts your program, you can then, in turn, expect to go to this physician for help in interpreting your program to other colleagues. An important aspect of this approach is that you are talking to a person about another person with whom he has intimate contact, rather than speaking to him in generalities which do not touch him intimately.

Support is often not this easy. Frequently you cannot meet the request of the professional because the request which is being made is inappropriate for the individual for whom it is being made, or because it is being made to the wrong agency.

The tact with which such a request is denied and the reasons for the denial may bring positive or negative reactions to your program. If, again, we are willing to spend added time in helping the individual and his family get to the more appropriate resource for service, we will usually have maintained the support of the referring individual; but we do need to take the time to call or write to let him know the reason for delay or denial, as well as to let him know why the other resource was recommended. This is an educational process, slow but worthwhile, and can be used with any profession.

I have discussed most of this as if it were easy, but it is not. It is slow, it is a continuous process as personnel is always changing, and there are also other impediments to enlisting the support of the professions.

We need to be aware of interdisciplinary and interagency support if there is to be coordination, and if we are to have this elusive comprehensive programing that we are planning for. To begin with we will have to learn to find better ways of communicating between the various professions so that we can find a language in which the words mean the same to all. Too frequently, we speak in a language understandable to our own profession, but not to others.

Further, we need to be aware that each profession has a special competence. The problem of retardation belongs to no one singly, but each of the professions must join forces to make a complete whole. Each profession may carry a major or a minor role at a particular time. Hopefully, someday our professions and our agencies will be strong enough within themselves that there will not be jealousy either among the professions or among the agencies. Until the time arrives when the focus of all personnel is on the needs of the retarded and on how to improve services and facilities for them, with each professional recognizing that he will or can provide only a small part in the continuum of services, we will have a long road to reach our goal.

These are some of the impediments that we have to surmount before we can easily move ahead to enlist the support of professional personnel, but it can and is being done.

Implementation of State Comprehensive Plans for Mental Retardation

Mr. Allen Menefee

MY REMARKS WILL BE centered on matters relating to implementation of legislation governing grants to States for planning comprehensive action to combat mental retardation. The initial legislation, the Maternal and Child Health and Mental Retardation Planning Amendments of 1963—Public Law 88-156, was recently extended for 2 years in an amendment to Public Law 89-97, better known as "Medicare." The amendment authorizes $2.75 million annually for fiscal years 1967 and 1968. Allocations will be made to the States on a population basis.

Under the new program for the continuation of planning and implementation of the plan, the minimum amount to be allocated to a State is $35,000. Allocations increase in accordance with population.

I see the relationship between this implementation and the ongoing job of developing and continuing plans for construction in some of the following ways:

First, both implementation and planning are one process—a unified whole. In many instances, while the comprehensive planning has been taking place, recommendations are being implemented. On the other hand, I expect that as we begin examining the recommendations that come from the published plans and attempt to implement them, other issues will be identified which require greater time and greater depth of study before conclusions can be reached.

Each State has its own way of approaching its own unique problems. For example, the plan for education of the trainable carried out in Ohio, is quite different from that of a State like Alaska which, in the course of its planning, passed a law requiring that public schools provide educational services to the trainable mentally retarded. Thus, in Alaska the question arises as to how local and Federal construction funds can best be utilized to meet the needs for public school classrooms for the trainable mentally retarded, as well as the complex needs of other levels of mental retardation and age groupings. Another type of situation presents itself in Rhode Island, where it is possible to provide preschool educational experiences for children from 3 years on up in the public schools. On the other hand, another State may be depending on the project Head Start for this type of activity.

Many other special situations can be cited. For example, there are issues around residential care. Does the State want to continue to house its retarded people in large institutions, or does it want to reduce the size of those institutions from 5,000 to 1,000 or possibly 500? Does it wish to take the approach of regional centers for residential care?

Has the State taken a look at the policy regarding admissions for residential care? Some States may operate under the philosophy that the earlier age group should not enter into residential care. Other States may decide that the very young child, the multiple handicapped, should be cared for in a highly specialized institution.

These are some of the issues that enter into how the plan for construction is adapted to the State. And so the comprehensive plan and the plan for construction are really intertwined.

I would see the construction planner and the

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comprehensive planner coming together with others involved to examine the priorities for the comprehensive plan and those set up by formula in each State for the construction plan.

These vary considerably from an approach of "them that has gets" to just the opposite approach of: "The have nots ought to get something."

Now, I can also see a hand-in-hand working together as implementation begins. For example, a certain area has been given a priority for diagnostic and evaluation services. Those involved in comprehensive planning should help that community develop the needed resources to operate such services. Moreover, assistance can be given in the development of an application for construction money.

It is important that the construction people carefully examine the philosophy written into the comprehensive plan. I continue to find people who have an idea for services they want to develop in what very closely resembles an institution. They say it isn't an institution because it isn't big—apart from the community. It seems when people get an idea for giving service they want to put everything into the package, residential care and all of the services, often in one building or one complex of buildings. The planners must therefore decide whether the proposal conforms with the philosophy that has been expressed in the comprehensive plan. If not, then every effort should be made to bring about a coordinated approach.

What type of staff members will be needed to implement a State plan? They would include planners, promoters, enablers, community organizers, persons who are a resource for resources, an expert on grantsmanship, and people who help the local community carry out part of its implementation.

Under the original legislation, four goals were established:

> First, to determine the action needed to combat mental retardation in the State and the resources available for this purpose.
>
> Second, to develop public awareness of the mental retardation problem and of the need for combating it.
>
> Third, to coordinate State and local activities relating to the various aspects of mental retardation and its prevention, treatment, or amelioration.
>
> Fourth, to plan other activities leading to comprehensive State and community action to combat mental retardation.

With the passage of the recent legislation extending the program, two additional goals have been added:

> First, to initiate the implementation and carrying out of planning developed under this title, and
>
> Second, to initiate the implementation of other steps to combat mental retardation.

That last goal covers considerable ground, so we are expecting to see a great deal of imagination used by the States in their implementation of the program.

Now, to anticipate a question. I am frequently asked whether or not an applicant can include in his expenditures the necessary cost for someone to work with the planning for the development of facilities or State plan for construction. The answer is "Yes—it is entirely up to the State." Such an employee should receive the same kind of consideration as other types of staff positions being proposed.

recommendations

Recommendations relating to health facility construction programs were considered by the conferees during group discussion periods held on the opening day of the 2-day conference. At a plenary session held on the second day, the following recommendations were adopted:

1. That the Surgeon General consider the population explosion, the need for modernization of health facilities, and the increased costs of construction when discussing the hospital and health facility construction needs of the Nation.

2. That the Public Health service regulations be revised to permit the use of Hill-Burton funds to construct projects not programed as comprehensive community mental health centers under Public Law 88–164, if approved by the State Mental Health Construction Authority.

3. That the Public Health Service be requested to develop criteria and standards whereby State agencies and communities may evaluate hospital outpatient services, needs, and resources including emergency room activities.

4. That the Public Health Service establish an administrative requirement in the interest of coordination which provides that no Public Health Service grant be made for health facility or health facility related construction without prior discussions with the State Hill-Burton agency.

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Association of State and Territorial Hospital and Medical Facilities Survey and Construction Authorities

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conference registration

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Mr. Clay Dean; Mr. William Fleming; and Ira L. Myers, M.D.

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U.S. GOVERNMENT PRINTING OFFICE: 1966 O—210-030